ASSISTING SCHOOL PERSONNEL WITH YOUTH TRANSITIONING FROM RESIDENTIAL TREATMENT TO A SCHOOL ENVIRONMENT

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ASSISTING SCHOOL PERSONNEL WITH YOUTH TRANSITIONING FROM RESIDENTIAL TREATMENT TO A SCHOOL ENVIRONMENT

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Abstract

The following research project examines the data and literature regarding youth who reside in residential treatment centers for behavior and mental health purposes. The paper introduces common risk factors that youth are experiencing which contribute to their placement in the facilities, as well as the difficulties they face upon exiting the treatment program. This project explores how schools can assist students in the transition from residential treatment to a school setting using a bio-ecological model that supports the students on an individual level up to a systemic level. School counselors serve as a key point of contact for transitioning students and can help teachers to understand this population and introduce supports both in the classroom and schoolwide. Teachers will also learn how to identify and modify potential negative stigmas, frustrations, and thought processes by practicing cognitive behavior techniques. The application resulting from the project is a counselor lead in-service for elementary through high school teachers, administrators, and student support services personnel.

Assisting School Personnel with Youth Transitioning from Residential Treatment to a School Environment

In 2010, 408,425 youth resided in out-of-home care in the U.S., including residential treatment, foster care, and committed youth (Lee et al., 2014). In 2006, approximately 200,000 lived in residential facilities for mental health, behavior concerns, and/or substance abuse (Trout et al., 2009). In 2012, Alaska had approximately 2,105 children (less than age 13) and 2,045 adolescents (ages 13 to 18) enter treatment for mental health, substance abuse, or co-occurring disorders (Alaska Department of Health and Social Services [DHSS], 2014). Those numbers increased in 2013 to 2,176 for children and 2,231 for adolescents. Youth may enter treatment for various reasons (e.g., substance abuse, behavior problems, and mental health) and some may exhibit more than one problem at the same time. Of Alaska's youth who entered treatment in the state in 2012, 74% enter for mental health concerns, 15% enter for substance abuse, and 12% enter for co-occurring disorders (Alaska DHSS, 2014). Youth with disruptive behavior disorders (DBDs) have high rates of comorbidity with other mental health issues, such as anxiety, attention-deficit/hyperactivity disorder (ADHD), and impulse control (Grothaus, 2013). For example, youth with oppositional defiant disorder have a 90% comorbidity rate with another mental health issue. Entrance into residential treatment can be voluntary, court issued, or by the request of parents/guardians and/or clinicians.

The definition of residence is "any setting in which children are placed with other children for at least one night with the goal of meeting health, education or other developmental needs" (Little, Kohm, & Thompson, 2005, p. 2). Youth placement is away from all family, except youth can have placement in the same facility as a sibling. Frequently, money is a determining factor for the quality and extent of care the individual receives at the residential

facility. For instance, many of Alaska children and youth with severe emotional disturbances were sent out of state for services and treatment because of the lack of in state services, costs, and insurance coverage (Armstrong, 2012). In 1999, Medicaid funding increased and many families with youth with severe emotional/behavioral disorders sought out assistance in statewide services. However, many of these behavioral health providers' treatment strategies were grant funded and much more difficult to practice with Medicaid funds (Armstrong, 2012). As a result, as many as 637 children were in out-of-state residential facilities in 2003 (Armstrong, 2012). This number has since dropped to 117 in 2012. Families with higher incomes may have other options, such as boarding schools, to provide care for children with emotional and behavioral needs and substance abuse issues (Little et al., 2005). Whereas, lower income families with children exhibiting similar issues will likely need to place children in publicly funded facilities (e.g., residential treatment centers, correctional facilities). Additionally, youth with DBDs (e.g., conduct disorder, intermittent explosive disorder, oppositional defiant disorder) cost an average of $70,000 more than youth without these types of disorders (Grothaus, 2013). Alaska's Division of Behavioral Health coverage for Medicaid clients concluded that in 2011, total payments for 1,907 children cost approximately $39 million (average $20,370 /person), 3,181 youth cost $102 million (average $32,163/person) and 4,727 adults cost $115 million (average $26,086/person) (Alaska DHSS, 2014). These costs highlight the importance for communities to identify the federal or state funds that are available for residents with mental/behavioral health concerns and to make sure funding legislation and programs are supported.

Internalizing and externalizing behaviors vary upon individual admittance into a treatment facility (Fite, Stoppelbein, Greening, & Dhossche, 2008). Externalizing behavior

problems are defined as "problems that manifest in an outward behavior (e.g., conduct disorder, substance abuse) and result in the child negatively acting on his or her external environment" (Fite et al., 2008, p. 64). According to the 2013 Alaska Youth Risk Behavior Surveillance System (YRBSS) in the high school setting, approximately 1,224 participants in grades 9 through 12 reported being in a physical fight (Centers for Disease Control and Prevention, 2013). Youth exhibiting externalizing behaviors tend to enter treatment at a younger age because these behaviors frequently disrupt the surrounding environments (e.g., family, school, community).

Internalizing behavior problems (e.g., depression, anxiety, withdrawal) are those that "negatively impact the child's internal psychological world rather than the external environment" (Fite et al., 2008, p. 64). In 2013, 27.2% or 1,194 high school students in Alaska reported feeling sad or hopeless almost every day and lasting 2 or more weeks (CDC, 2013). Youth with internalizing behaviors typically enter a treatment program at a slightly older age because their behaviors are unnoticed by family, friends, or teachers. Most families seek treatment services for externalizing behaviors; however, many youth experience co-occurring externalizing and internalizing problems. Youth with co-occurring problems are the largest group for outpatient services (Fite et al., 2008). Literature suggests that minority groups are over pathologized and diagnosed harshly compared to White people. For example, American Indian/Alaska Native (AI/AN) people tend to have higher rates of behavioral health concerns because of historical traumas, forced acculturation into society, diminished society and family structures, poverty, and shortages of economic prospects (Podlogar & Novins, 2015).

Once youth complete the residential program, they immediately rejoin the community, educational, and social settings. Alaska's Department of Health and Social Services (2014) reported in 2013 that 44% of children in treatment received services for more than a year, and the

majority of youth (37%) in treatment were likely to receive services for 6 to 12 months. This population re-enrolls in the school system and must integrate into the general population, while maintaining the goals established in treatment. Relapse is difficult to overcome in these environments, and research shows that the younger an individual is upon the first admittance to treatment, the increased likelihood for program re-admission (Fite et al., 2008). One study showed 45% of 184 youth returned to treatment by the 7-year follow up (Hair, 2005).

Youth in treatment often overestimate their abilities to easily transition back into their community. This perception is known as positive illusionary bias (PIB) and individuals frequently exaggerate their abilities in areas of greatest difficulty (Casey et al., 2010). For employers and teachers, detecting PIB in students may be difficult because students may appear fine when they are actually struggling. Adults need to be patient with returning youth and observant of behaviors and grades that may symbolize hidden areas of difficulty. Hair (2005) mentions several components that help form a healthy life, such as resiliency, good self-esteem, social competency, and at least one positive relationship with an adult. Furthermore, according to a study by Nickerson, Colby, Brooks, Rickert, and Salamone (2007) of 20 residential youth, 85% reported feeling very confident in their ability to deal with others, 95% having a positive adult relationship, 95% having a close friend with a positive influence, and 90% reported having internal strengths. Despite these positive ratings, youth transitioning from treatment programs do have several, legitimate concerns. According to Casey et al. (2010), residential youth had primary concerns about getting along with family, finding a job, and going back to school upon exiting the program. Unfortunately, studies have shown that approximately 72% of those youth who do return home have family problems (e.g., abuse, domestic violence, neglect) (Trout, Huscroft-D'Angelo, Epstein, & Kavan, 2014). As part of a transition plan, communication

between the residential facility and the youth's school was very important to the youth and their parents. Regardless of the desire by youth and family to keep a school connection while at a treatment facility, slightly more than 50% of residential staff kept the youth in contact with their home school, and 58% of residential staff replied as rarely or never contacting the youth's school at post-release (Nickerson et al., 2007). These inconsistencies in communication and follow up of aftercare services with outside providers are detrimental to the youth. Without the knowledge of the child's aftercare plans, school personnel often guess how to best work with youth returning from residential facilities. Schools can try to connect youth with some of the services and increase their awareness and knowledge base of this population to assist in the development of behavior plans and academic goals.

Program effectiveness of residential treatment facilities is an ongoing issue and very little research is available. Relapse and readmission of youth can affect a community tremendously, resulting in youth dropping out of school, lacking employment skills, and having higher rates of arrests and problem behaviors (Trout et al., 2014). On the contrary, residential treatment facilities recognize the importance of creating transition and aftercare plans for their clients, but there appears to be a lack of information that assists schools to do the same.

Risk Factors

There are several factors that can influence or heighten the chances that a youth develops a DBD (Grothaus, 2013). Biological or neurological findings show executive functioning, which assists in self-regulation, is most important for school success. The mental health of the parent or guardians is also a contributing factor, as well as parenting styles. Youth who have received a DBD diagnosis likely have a parent or guardian that struggles with at least one mental health disorder (Grothaus, 2013). Furthermore, youth who experience neglect, abuse, and family

violence, for instance, may have higher risks of developing DBDs. Of Alaskan youth in treatment in 2011, about 56% reported signs of neglect, 48% reported physical abuse, 48% reported emotional abuse, and 40% domestic abuse (Armstrong, 2012). These percentages include youth receiving services in and out of Alaska. When comparing the two groups, the percentage of trauma factors experienced were higher for youth in out-of-state treatment in 9 out of the 10 areas (Armstrong, 2012). Youth in treatment have increased rates for lacking problem solving skills, empathy, self-regulation, and positive adult relationships (Grothaus, 2013). Environmental factors, such as poverty, deviant social groups, and exposure to violence, can also influence DBD rates. From a cultural perspective, African American youth, Native Hawaiian youth, and those in a lower socioeconomic status have higher rates of DBDs, in comparison to their White peers (Grothaus, 2013). Students of color also have higher rates of disruptive behavior diagnosis than their White peers, but are more likely to be misdiagnosed (Grothaus, 2013). Students of color access mental health services less often than their White peers and have higher rates for the termination of services. Podlogar and Novins (2015) mention several barriers that influence American Indian/Alaska Native people's individual experiences with behavioral health services. Barriers of distrust include lack of cultural knowledge by the health professionals, discrimination, and ignorance of the effect of historical traumas on American Indian/Alaska Native peoples. It is important for health workers and school personnel to not put blame on the individual, but rather look at the systemic problems that may foster monocultural values and beliefs, which leads to institutional racism (Sue & Sue, 2013).

Furthermore, only 20-30% of students needing additional mental health services actually find services in the community (Grothaus, 2013). In rural areas, health services are limited. The services may be poor or of unacceptable quality, lack specialized services, require traveling great

distances, long waiting lines, and/or have few staff personnel or appointment options (Podlogar & Novins, 2015). As a result, Alaska youth who need behavioral/mental health services may be sent out of state to residential psychiatric treatment centers. In 2003, 637 Alaskan youth were placed in out-of-state treatment facilities (Armstrong, 2012). "Bring the Kids Home" is an initiative that began in Alaska in 2004 to focus on children with, or at risk for, severe emotional disorders and providing supports and resources in Alaskan communities to decrease the number of youth sent out of state (Armstrong, 2012). Given the associated risk factors and high rates of children with DBDs and with the high numbers of youth in out-of-home care and residential treatment placement, this research project will address the following question: how can school counselors help school personnel assist students who are transitioning from residential treatment for behavior and mental health issues to the school setting?

Literature Review

The section will begin with a review regarding the theoretical framework and reasons for treatment. The paper will then discuss post-treatment aspects including transition difficulties, supportive factors, and effective treatment factors. It will follow with potential areas for staff education including behavior referrals, behavior modification, and special concerns for youth with disabilities.

Theoretical Framework

Urie Bronfenbrenner developed an ecological model that studies the relationship between the environment and biological factors that influence child and adolescent development (Brendtro, 2006). He believed children were not solely responsible for their poor behaviors and decisions, and identifies key circles of influence that affect a child or adolescent, either directly or indirectly. Bronfenbrenner believed that "every child needs at least one adult who is irrationally crazy about him or her" (Brendtro, 2006, p.163). This model represents the layers of

influence that surround an individual. This section will also introduce cognitive behavior therapy (CBT) as a beneficial framework for counselors to teach school personnel who work with students with behavioral or mental health needs. CBT offers a framework which mentions individuals have core beliefs that shape who they become and their perceptions of the world, people, and the future (Henderson & Thompson, 2011).

Bioecological model. In his early studies of human development, Bronfenbrenner's first phase (1973-1979) of the model identified key systems that influenced the individual: microsystem, mesosystem, exosystem, and macrosystem (Rosa & Tudge, 2013). The microsystem defines the youth's immediate environment where the effects of the relationship have direct impact on the individual. This system includes individuals like family members, peers, teachers, and one's neighborhood. The mesosystem identifies the relationships between two or more of the individuals in the microsystem (Gabbard & Krebs, 2012). Interrelations between parents and teachers is an example of mesosystems. Settings that do not directly influence the individual are part of the exosystem. The exosystem may comprise a parent's workplace, extended family members, and the media (Gabbard & Krebs, 2012). The macrosystem is the cultural and societal setting that surrounds the individual. It was not until his second phase (1980-1993) that Bronfenbrenner began to question how child and adolescent development was influenced by events or occurrences over time and thus he added the chronosystem. An example of the chronosystem would be for politicians to observe how social policies influenced communities, families, and individuals over 5 years (Rosa & Tudge, 2013). The chronosystem would also include the impact of historical traumas on Alaska Native people. The bio-ecological model shares similar traits to that of a butterfly effect. A butterfly effect explains that one change in detail in an event or situation could cause major changes to the

outcome and everything involved. The change in any one thing will ripple down to the child, thus having a positive or negative effect (Gabbard & Krebs, 2012).

Bronfenbrenner's ecological model continues to assist counselors and educators in understanding how environmental factors can affect a child and adolescent's development on multiple levels (e.g., microsystem, macrosystem, mesosystem, exosystem, and chronosystem). Counselors can use Bronfenbrenner's bio-ecological model to identify the support systems present or lacking for the student. Because this model functions as a holistic view of the youth, it blends well from a cross-cultural perspective where family relationships and the surrounding environments are important to the values and belief systems of certain cultures. American Indian/Alaska Native populations tend to rely more on their own resources (e.g., family, friends, traditional healing practices), rather than seeking assistance through Westernized medicine services (Podlogar & Novins, 2015). By using a bio-ecological model, school staff are directed to explore and engage in the various systems that can support the student instead of relying immediately on Westernized practices as solutions that may not align with the student's cultural beliefs. To increase positive behaviors and success rates of the students, counselors can work with the school staff and advocate at the district level to develop or modify the systems surrounding the youth.

Cognitive behavior therapy (CBT). In the 1960s, Aaron Beck challenged Freud's thinking of how external behaviors determine internal thought processes, such as outwardly expressed anger causes depression (Kottler & Shepard, 2011). Beck believed that depressed individuals had negative cognitive distortions that influenced how they perceived their surroundings. His research supported that maladaptive thoughts could influence the development of psychological disorders. In early childhood, individuals create belief systems

and assumptions called schemas. Beck believed these schemas influence one's decisions and interpretations in daily situations throughout a person's life (Kottler & Shepard, 2011).

Cognitive behavior therapy (CBT) has a primary goal to relieve the individual's emotional distress (Kottler & Shepard, 2011). School counselors can work with school personnel to identify the core belief systems that may influence a negative self-concept and begin to recognize faulty thinking or unrealistic thoughts towards students (See Appendixes F and G). Staff is encouraged to unconditionally accept themselves and their students and understand that people make mistakes and have flaws, but may still be an overall good person. Adults can learn and feel confident when implementing strategies into the daily interactions with youth exhibiting disruptive behaviors. It is easy for frustrated and stressed adults to have an all or nothing mind frame when working with a youth who is acting out (See Appendix H). Thoughts, such as nothing works, run through parent and teacher's minds, but this mindset also limits the adult's confidence in the relationship with the youth (Levine & Anshel, 2011). Levine and Anshel (2011) mention core components of CBT can help teachers cognitively reframe their negative thoughts towards youth with behavior issues in the classroom or school setting. Teachers learn to catch negative thought processes and schemas and restructure the thought into a more realistic belief. When a teacher has high expectations for a student, the student is more frequently called upon, and may receive more forms of encouragement (Guerra, Boxer, & Kim, 2005). Students showed increased levels of achievement, revealing that teacher's perceptions of students can negatively or positively influence the student's level of achievement. Counselors can practice with the school staff to use positive self-talk and reframe negative thought processes to assist in difficult situations with students.

By school staff practicing CBT techniques and implementing supports through a bioecological model, the everyday environments (e.g., school, home, community) become agents of change for behavior modifications and improvements for a struggling student. Guerra et al. (2005) believe that an ecological and CBT framework combined can show the greatest improvements for youth with behavior issues and the school staff working with these students. This cognitive, ecological model identifies the main problem behaviors that emerge are learned through socialization, maintained overtime, and shaped through observational learning experiences (Guerra et al., 2005).

Post-Treatment

Post-treatment plans are extremely important to make sure the youth leaving treatment has an aftercare plan, which is a continuation of skills learned in treatment (Hair, 2005). This section will discuss several studies that show program factors that lead to effective treatment discharge, program to community discharge difficulties, and supportive factors (e.g., family, goals, and education).

Effective treatment factors. Hair (2005) tracked youth treatment outcomes from residential treatment programs from 1993-2003 and identified the effectiveness of the programs as they led to successful program departure. A successful discharge was defined as the resident completed the program, staff felt the individual exhibited successful levels of emotional and behavioral changes, and the individual transitioned to a less restrictive, intrusive environment (Hair, 2005). Family involvement, duration of treatment, consistent expectations, and structure were key factors for determining which programs led to successful discharges. One of the studies included in the Hair (2005) study collected responses from 222 placement workers. These participants stated that youth ages 9 to 17 were more likely to achieve their goals and

graduate from the program when family involvement and visitation during the treatment process was high (Hair, 2005). Family involvement during the treatment process and after care is important and could be an issue for families who have children who enter treatment outside of the state.

Podlogar and Novins (2015) did a similar research on how American Indian youth and their parents perceived the quality of care at their behavioral health treatment program. The study interviewed 16 parents and 11 youth about the child's experience and treatment outcome. Parents established that trust with the clinician was a central concern, followed by good communication, sensitivity, and respect. Two-thirds of the parents felt the treatment process was respectful and sensitive of their cultural beliefs. Staff listened without making assumptions and asked thorough questions about the family, home, and school (Podlogar & Novins, 2015).

Transition difficulties. Nickerson et al. (2007) explain three key areas of difficulty youth have transitioning out of residential treatment: the long-standing nature of the problems, lack of change in family dynamics when youth returns, and lapses in the continuation of treatment after release. Seventy-two percent of youth in a study by the Administration for Children and Families stated they experienced family problems (e.g., parental neglect, domestic violence, abuse) upon their transitioning out of treatment (Trout et al., 2014). Nickerson et al. (2007) conducted structured interviews with 62 individuals in a residential treatment center. The population interviewed consisted of 21 staff members, 21 parents/guardians, and 20 adolescent residents. Seventeen of the youth were current residents and three were recently discharged. It was found that lapses in continuing treatment occur partially because of the lack of inter-agency communication (Nickerson et al., 2007). As mentioned previously, almost half of the parents and students reported communication to their home school and education was an important

factor for transition, yet 58% of the staff members reported "rarely" or "never" contacting the youth's school about aftercare or transition plans (Nickerson et al., 2007). Communication with any family is expected so the family feels part of the treatment process and lack thereof is a common reason for mistrust in service providers for AI/AN families (Podlogar & Novins, 2015). In addition, Casey et al. (2010) stated 32% of youth worried about their relationships with family members, likewise, Nickerson et al. (2007) reported 63% of the participants had this same worry. The largest concern for youth in the Casey et al. (2010) study was the influence of peers as the youth transition back into the community. Forty-six percent reported concerns with reintegrating with their peers. A follow-up study of youth previously in residential treatment reported 42% had been arrested, 12% struggled with drug abuse, and 21% had alcohol problems (Trout et al., 2014). Other topics of concern included finding employment and starting back to school. Even though the youth learn coping strategies and effective techniques to live a healthy lifestyle in treatment, it is increasingly difficult for youth to feel comfortable and confident with implementing these strategies at home or amongst friends (Casey et al., 2010).

Supportive factors. Casey et al. (2010) discussed a study that involved 104 youth, ages 10-17 years old, in a Boys Town Treatment Family Home. Family Teachers modeled appropriate behaviors and taught life skills for the youth for an average period of two years. The purpose of this study was to identify and evaluate the characteristics that led to successful reintegration of youth from residential care (Casey et al., 2010). Data was collected from small group interview, Family Teachers and school teachers, and youth demographic information. Researchers found that 41% of the youth planned on living with their parents post-treatment, and were able to identify three adults for emotional, informational, and tangible support. The most frequently listed individual in all three areas was their mother, which

indicates this may be one of the strongest relationships for the youth. Many of the students answered that they had the necessary skills (e.g., family living, self-determination, building relationships, and preparedness post-treatment), but teacher perceptions on the self-determination scale were much lower. As mentioned previously, this possible discrepancy between the teacher and youth perceptions of their abilities is termed positive illusionary bias (PIB) (Casey et al., 2010).

Similarly, Trout et al. (2014) composed a Youth Aftercare Survey that was distributed to 132 youth transitioning out of residential care during a three-month time span in 2010. These youth lived in Treatment Family Homes, where approximately eight youth ages 12 to 18 resided with a married couple and an aide in a community-based family style home. Youth were asked about their perceptions of aftercare and transition support. Between 75% and 80% of youth believed transitions plans will be very helpful and felt very involved in the development of the plans. Youth felt more prepared transitioning home than they did transitioning to school. School personnel would want to focus on strengthening this transition by involving and communicating with the youth's family on a regular basis. Additionally, school personnel would want to know what the best means of communicating with the family are, such as by phone, email, text, or in person. Another domain of the survey asked students to rank level of importance and preparedness in seven domains: community involvement, education, family, independent living, mental health, physical health, and relationships (Trout et al., 2014). One hundred percent of these students stated they would like supports in areas of education, 93.8% in family, 94.7% in physical health, and 97.7% in relationships prior to their departure. These categories express strengths that will assist in successful reintroduction into the community, home, and school settings. Youth also ranked money management skills, developing relationships, career

planning, enrolling in school, and developing homework routines and a healthy lifestyle as some of the top ten supports and services for reintegration (Trout et al., 2014).

Another form of support would come from the school's knowledge of the student's treatment history and aftercare plan post-treatment. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule ensures privacy of an individual's health and medical records through national standards (U.S. Department of Health and Human Services [U.S. DHHS], n.d.). The Privacy Rule national standard establishes the conditions and limits to which client private health information is disclosed to other parties per the patient's request (Alaska Department of Health and Social Services, 2015; U.S. DHHS, n.d.). In order for school personnel to receive a student's treatment information, the student and parent or guardian must complete an authorization form or release of information (ROI) that permits selected health information to be released to the school. Examples of ROI forms for the Juneau and Anchorage School District are available in Appendix D.

School Implementation

The bioecological framework has significant influence as to the various setting in which behaviors of concern are further supported and learned. Problematic behavior modification can stem to larger, school wide policy changes. Guerra et al. (2005) mention that problematic behaviors lessen when teachers feel the administration follows consistent and effective policies. Therefore, when teachers feel the support of the school administration, behavior modification strategies can begin in the classrooms. Many of the following school-wide policies (e.g., Response to Intervention, Positive Behavior Intervention Supports) monitor office referrals as precursors to the level of support the student may need either academically or behaviorally (Gruman & Hoelzen, 2011; Muscott, Mann, & LeBrun, 2008). Unfortunately, most if not all of

those referrals are driven from adult responses and perception to the problematic situations and disproportionate for students of color compared to their White peers (Bryan, Day-Vines, Griffin, & Moore-Thomas, 2012). In order for these programs to be effective, schools need consistency in how office referrals are written. Prior to the school year, staff need to be aware of situations that constitute for a referral, timeliness of the referral, and the steps to complete the office referral in order to increase consistency and fidelity in school-wide program implementations (Kalberg & Lane, 2010). Lastly, schools should be aware of their local trends and data in the school and community.

School counselors can inform the school personnel on how to work with youth returning from residential facilities and some of the concerns that may arise. Youth of all races, academic levels, and socioeconomic status can exhibit behavior and mental health problems that constitute for placement in a residential treatment facility. Furthermore, approximately 10% to 31% of youth in residential treatment have a disability (Trout et al., 2009). Schools need preparation for assisting students in the transition from treatment to the academic setting. A main objective for aftercare is to ensure the youth has all the tools to lead a healthy life, maintain positive gains made in treatment, and prevent recidivism (Trout et al., 2014). School staff members are present with students roughly 7.5 hours a day and by developing a caring relationship, the teachers can observe changes in the student's behavior during the transition. Fite et al. (2008) report that youth admitted into residential treatment have a number of externalizing and internalizing behaviors that can affect them in the school setting. About 88% have difficulty following directions and 58% have school behavior problems. Depression and withdrawal is common also (Fite et al., 2008). Forty-five percent of 372 youth reported having these feelings upon admission into the residential facility.

Some of the biggest concerns in schools are how to manage problematic behaviors in the classroom. Research supports that antisocial boys, when around one another in group settings, tend to heighten one another's aggressive behaviors (Little et al., 2005). Not only are administrators and school counselors trying to identify best practices schoolwide, they must have practices in place to assist students with heightened behavioral and/or emotional needs. Previous studies have shown that nearly 75% of youth who return to educational systems from residential treatment facilities perform below grade level and are twice as likely to drop out (Trout et al., 2014). These components then contribute to the youth's functionality at home, school, and in the community. With an increase in school personnel understanding the needs of this population, returning youth will have more adults with whom to confide and assist them to meet their educational goals.

Teachers may learn about the disproportionality dilemma which claims that suspensions and behavior referrals to school administration and school counselors is biased depending on the student's race, gender, and previous discipline referrals (Bryan et al., 2012). It is easier for schools to blame the individual for their inability to be successful at school, rather than look at the systemic issues that are supported by the school and social environment (Sue & Sue, 2013). Students with previous discipline referrals have a tendency for increased supervision during the school day and may get in trouble for minor issues in comparison to their peers. Research supports that suspensions, repeated referrals, and expulsions are detrimental to the youth because they lead to further disengagement from the school environment, negative image of school, dropping out, and incarceration (Bryan et al., 2012; Grothaus, 2013). School counselors can introduce the idea of wraparound services and behavior management strategies to school personnel to help assist students returning from residential treatment. Each of the programs,

however, need to be mindful of how the services can be applicable cross culturally. The services provided at each of the levels must be applicable for all students. Sue and Sue (2013) mention that educators feel the reasons for the ineffectiveness of working with culturally diverse populations is because of the lack of culturally sensitive materials provided in the curriculum and the school-wide implemented programs.

Schoolwide supports. This section introduces two possible programs that schools can implement to deter and improve problematic behaviors for all of the students (See Appendix E for example cases). Alaska staff and students noted that student's risky behaviors decreased when they held increased levels of school connectedness and perceptions of school climate (American Institutes for Research, 2014). Furthermore, both of the programs to be discussed are common in elementary through high schools and have significant research that supports their effectiveness in reducing maladaptive behaviors and improving education from student and teacher standpoints. Refer to term definitions in Appendix B.

Response to intervention (RTI). This section provides a basic understanding of the RTI model and example cases are discussed in more detail in the behavior modification section Response to Intervention (RTI) is an approach that school districts are implementing across the nation. Gruman and Hoelzen (2011) discuss how the RTI three-tiered model addresses academic and behavioral concerns, but support school counselor's as a critical team member for data collection and implementing individual interventions, as they pertain to the RTI model. It is important for schools to know each individual entering their school because the student may represent characteristics that require support both behaviorally and academically. The first level includes school-wide supports that are often implemented by general education teachers in their classrooms. Tier 1 strategies could include behavior management, social skills programs, and

high quality instruction (Gruman & Hoelzen, 2011). At this level, counselors may collaborate with teachers on engagement strategies, transition programs for new students, and school wide conflict management. Office referrals are often used by school counselors to decide which students may need Tier 2 supports.

If Tier 2 interventions are being considered, the counselor gathers student data from the student's cumulative file, assessment scores, previous meetings with the teacher and student, and observations (Gruman & Hoelzen, 2011). Students at Tier 2 still receive the supports from Tier 1 in addition to more targeted supports. At this level, the student may receive small group interventions for academic and/or behavioral difficulties. Academically, the student may receive small group instruction for math or reading. Behaviorally, the counselor would lead a small group of students in topics regarding difficulties with social skills and behavior management. School counselors may also coordinate meetings with parents and teachers to align goals or discuss mentoring programs (Gruman & Hoelzen, 2011). If these students show improvements in their academics and grades over a period of time, they may no longer need Tier 2 interventions and will then return to Tier 1. If a student's progress were not improving with Tier 2 supports, the student would then move to individualized interventions in Tier 3.

Students in Tier 3 with academic concerns may qualify for Individual Education Plans through the special education team. For those students with behavioral concerns in Tier 3, school counselors may look at individual counseling, behavior management plans, and supports from community resources (e.g., mental health counseling, behavior evaluations, or forms of treatment) (Gruman & Hoelzen, 2011). When students with DBDs reach Tier 3, they may be eligible for 504 services. Students with DBDs who do qualify for special education supports typically fall under an emotional disturbance category (Grothaus, 2013). For students with

DBDs, the RTI model can be a great resource for students to receive on-going supports through the three-tiered system.

Positive behavior intervention supports (PBIS). PBIS requires a five tiered change system that trains and supports schools to create positive learning environments by implementing effective behavioral practices and processes school wide (Muscott et al., 2008). Administrators first explore or increase their *awareness* of PBIS by meeting with PBIS leadership to decide whether to introduce the staff to PBIS. If there is an *interest*, the staff will explore the needs of the school and work towards timelines, outcomes, trainings, resources, and requirements to adopt PBIS practices (Muscott et al., 2008). The site enters the *readiness* stage as staff becomes committed to PBIS, develops a team that overlooks the process, and begin training. *Implementation* occurs in the fall of the school year where the school leads a schoolwide introduction or rollout of services for students, parents, and all staff. Lastly, *sustainability* ensures that staff receives ongoing training and technical assistance, data collection continues, and PBIS becomes part of the school climate.

PBIS is effective throughout the K-12 system in reducing office referrals, increasing teacher instructional time, and increasing administrator time (Muscott et al., 2008). The program focuses on the shifting of school behavior management processes from traditional punitive measures (e.g., office referrals, suspensions) to teaching positive, appropriate behaviors through three levels of prevention. The first stage is universal prevention that focuses on at least 80% of the school population to learn strategies that lessen problem behaviors, increase positive interactions with peers and adults, and increase achievement (Muscott et al., 2008). The secondary stage focuses on approximately 5%-10% of youth at-risk for behavior or mental health needs. PBIS would assist by reducing the opportunities for maladaptive behaviors to occur and

increasing exposure to prosocial systems (Muscott et al., 2008). The tertiary stage focuses on 1% to 5% of students with behavior or mental health concerns. This stage works towards reducing the frequency and intensity of problematic behaviors and replacing them with positive behavior systems.

A study that took place in 28 K-12, New Hampshire schools over a two-year implementation, showed that participating schools had a 28% reduction in office referrals and a reduction of 25% in suspensions (Muscott et al., 2008). Teachers recovered 864 days of teaching, students gained 1,701 days of education, and administration gained 571 days of leadership. This information further supports the need for positive behavior supports in schools in order for youth with behavior or mental health needs to be successful in a school setting. The Muscott et al. (2008) study will be discussed in more detail in the section regarding behavior management.

Individualized school supports. The following section discusses three key interventions that are often established for students with behavioral, mental, or special needs. IEPs, 504 plans, and functional behavior assessments are interventions that may be established in Tier 2 and Tier 3 of the RTI and PBIS models. Refer to term definitions in Appendix B and a visual that distinguishes youth referrals for an IEP or 504 plan in Appendix C.

Individual education plan (IEP). Through the Individuals with Disabilities Education Improvement Act (IDEA) of 2004, schools must provide a list of mandated services to students with disabilities. As mentioned previously, up to 31% of youth in residential treatment have a learning disability (Trout et al., 2009). The youth will undergo several assessments that will identify any academic or functional performance discrepancies (U.S. Department of Education, 2006). Part of those services requires that a student who qualifies as having a disability receive

an Individual Education Plan (IEP) that will list measureable goals and supports that will assist the student to make academic progress (U.S. Department of Education Office of Special Education Programs, 2006). A student's progress toward the goals is monitored quarterly and annually. To help achieve some of the goals, the IEP often includes modifications of the academic work, as well as, accommodations that include supplementary aids to assist in academics (U.S. Department of Education, 2006). Furthermore, with the new revisions to IDEA in 2004, individual states no longer have to prove severe discrepancies between an individual's academic ability and their intellectual ability (Gruman & Hoelzen, 2011). Some programs described in the next sections act as stepping-stones for students with or without disabilities. The programs introduce various interventions that can assist a student who is struggling with academics, behaviors, and/or mental health before receiving formal documentation through an IEP or 504.

504 plans. Section 504 of the Rehabilitation Act of 1973 was established to end discrimination towards disabled individuals in any facilities or activities that receive funding from the federal government (Madaus & Shaw, 2008). Originally, section 504 was assisting individuals with disabilities in the work environment. Schools were in compliance with IDEA and assumed that all students with disabilities were supported under IDEA, but that was not true (Madaus & Shaw, 2008). Not all students with disabilities were covered under IDEA. In 1991, the Office for Civil Rights (OCR) ensured that all programs, especially schools receiving federal funds, support students with disabilities if they do not qualify for special education services provided under IDEA (Madaus & Shaw, 2008). In order to qualify for a 504 plan, the student must have a physical or mental impairment that substantially limits one or more major activity, have a record of such an impairment, or be regarded as having such an impairment (U.S.

Department of Education, Office of Civil Rights 2015). Some diagnoses that could obtain 504 supports include, students with attention deficit/hyperactivity disorder (AD/HD), post-traumatic stress disorder (PTSD), traumatic brain injury, arthritis, autoimmune diseases, severe allergies, cerebral palsy, or temporary impairments (e.g., injuries sustained in a car accident). There are various types of accommodations available for students in the school setting, depending on the individual's disability or diagnosis. Accommodation supports can help to "level the playing field" and remove the barriers that may prevent a student with disabilities equal access to education and extracurricular activities (Fraczek, 2013). Accommodations can help students in difficulties with attention, written language, organization and planning, impulsiveness, and social emotional concerns (Alpine School District, n.d.). Some examples of accommodations are time extension for assignments and assessments, placement of the child's seat in the classroom, behavior contracts, and frequent breaks.

There are several levels of 504-policy management within a school district (Madaus & Shaw, 2008). One study examined 259 elementary through high school education professionals and their knowledge of 504 compliance and practices in their schools in one northwestern state (Madaus & Shaw, 2008). The study helped researches to identify that most of the respondents had served on a 504 team and 58% had more than 15 years of school experience. Knowledge of which school professionals serve as 504 representatives varies from school to school, but is important information for all staff to know the process. Typically, the superintendent makes sure that the schools are in compliance with Section 504, whereas the special education department is frequently the district coordinator. Thirty-two percent of district 504 coordinators are the special education directors. Approximately 18% of school-based coordinators are the principal, assistant principal, or school counselor. Forty-eight percent of 504 meetings are run by the school

administrators, followed by of school counselors who run 39% of them. Forty-three percent of school counselors are the managers of the 504 plans, followed by 38% of general education teachers. The study points out the importance of educating school personnel regarding the 504 process as an integral part of teacher preparation and ongoing training. While most respondents had received 504 training within the last 5 years, almost 70% said it was not part of their teacher preparation training, and 28% mentioned they had never attended a training on 504s (Madaus & Shaw, 2008). 504s are such an important component and service available for students with behavior and mental health needs that it is critical for school personnel to be knowledgeable about Section 504 process, including training opportunities, and its applicability at their site.

Functional behavior assessment (FBA). A functional behavior assessment (FBA) assists school staff with identifying the dynamics of a student's behavior through problem solving (See Appendix B). Parents, educators, and agency personnel work together to design a plan that will help the student learn and implement positive and more appropriate behaviors (Alaska Department of Education and Early Development, 2013). The FBA consists of a series of steps. First, those involved with the student document the behaviors of most concern and provide descriptions of the problem behaviors. Second, additional information is gathered from the student and parent, such as medical or physical concerns, routines, prior stressful events, and any history of abuse. The team can process to see if any of the information learned may be related to the school behaviors. Third, the team goes in depth to break down the situation where the observed behavior occurs. Examples of questions would involve noting the time of the day, who is around or involved, and where is it occurring. This stage helps to predict when the targeted behavior may occur. Results, for instance, will identify what the student may be seeking (e.g., attention, avoiding schoolwork). Fourth, the team moves toward understanding the

consequences in place and maintaining factors of the behavior (Alaska DEED, 2013). For example, the team addresses how students and adults respond to the behavior, as well as whether the student is likely to stop or proceed with the behavior. This step helps to determine the function or maintaining factors for the targeted behavior. The fifth step develops a theory that uses data from the previous steps to help determine why or how a student engages in the identified problematic behavior. The team will have a general idea as to what the behavior looks like, the setting in which is occurs, and outcomes that may maintain the behavior (Alaska DEED, 2013). It is important to remember that the FBA results come from all the staff that work with the individual to help identify environmental factors that may influence when problematic behaviors occur (Levine & Anshel, 2011). Once an FBA has been completed, the team will design a behavior intervention plan (BIP) that lists the positive intervention strategies, supports, role responsibilities, timelines, and consequence methods (Alaska DEED, 2013). The BIP includes ongoing data tracking and support for the measurable goals that will help to increase positive behaviors and decrease problematic behaviors.

Unlike some of the previously mentioned school strategies, individuals do not have to have a formal diagnosis or qualify for learning disabilities to receive supports through a FBA/BIP. FBA and BIPs are tools for students with behavior problems and can help reduce school exclusionary practices, such as suspension and expulsion (Alaska DEED, 2013).

Staff Education

This section of the project discusses a disproportionality dilemma with student referrals to the school counselors and office, behavior modification plans, and returning youth with special needs. By learning about some of the behavior referral trends, school personnel can become more self-aware of how they may treat or reprimand students differently based on

various factors, such as gender, ethnicity, and teacher expectations of the students. Additionally, behavior modifications plans are pertinent for the continuation of aftercare support in the schools. The demographics of youth in treatment vary tremendously. School staff will further explore the characteristics for those youth in treatment with special needs and the necessity of aftercare supports in the school by looking more thoroughly at several studies previously mentioned.

Behavior referrals. Bryan et al. (2012) introduce the idea that school referrals for disruptive behaviors are disproportional. Acknowledged by the National Center for Education Statistics (NCES), Latino and African American students face twice as many school suspensions in comparison with White students. According to an Indiana study, suspension rates show an increase in numbers; Hispanic students are twice as likely and African American students four times more likely to be suspended than their White peers (Bryan et al., 2012). The article mentions that ethnically diverse students have an increased likelihood for counselor referrals for behaviors involving disrespect, threats, and excessive noise. On the other hand, their White peers will receive behavioral referrals for objective offenses, such as leaving class early, smoking, inappropriate language, and vandalism.

Bryan et al. (2012) indicate a study by the NCES determined higher rates of suspensions and disruptive behaviors depending on the subject area of the class. The information gathered also tracked how many students were referred to school counselors and on what conditions. Data from 4,607 tenth grade English students and 4,981 tenth grade math students was collected in 2002. The study makes note of whether or not the teacher spoke to the school counselor concerning a student's behavior. Independent variables included student demographics (gender, socioeconomic status, race/ethnicity, and current level in math and reading), acknowledging the

school as suburban, teacher demographics, prior student behavior history, and teachers' educational expectations for the students. Along with various student ethnicities and demographics, the research also looked at whether the student's gender was a factor for a behavioral referral.

The results for the NCES data revealed the differences in English and math student referrals based on gender, ethnicity, and the teacher's post-secondary expectations (Bryan et al., 2012). Gender played a role in English and math teacher referrals. In an English class, males were three times more likely to be referred to school counselors than females. However, when comparing race and gender in an English classroom, multiracial females were three times as likely to receive referrals. There was no correlation between race and gender for behavior referrals in the math classes, but males were twice as likely to be referred (Bryan et al., 2012). African American students were most likely referred from English teachers, whereas race was not a factor for math teacher referrals. Additionally, teacher's post-secondary expectations affected students in both the English and math classroom. The NCES summary states that math and English teachers referred students whom they felt had little post-secondary expectations more frequently than others. This sparked the concern of the biases that are present in the school system and for school personnel to be aware of their classroom practices.

As mentioned previously, the New Hampshire K-12 school study researched the impact PBIS could have in schools (Muscott et al., 2008). This study started in 2002, as administrators attended a 2-day event to discuss whether the PBIS model would be a good fit for their school. Administrators agreed to 10 commitments as part of the application process for implementing PBIS (Muscott et al., 2008). PBIS is a systems approach to change behaviors through teaching social behavior, emphasizing positive and preventative strategies, creating individualized

strategies for students with intensive needs, collaborating with families and community members, and creating school based teams that can address the 3-levels (Muscott et al., 2008). The school agreed to have at least 80% of school staff committed to implementing PBIS strategies. This study reached 38,000 children. Twenty-two of the schools collectively reduced in-school suspensions by 31% and out-of-school suspensions by 19%. However, out-of-school suspensions increased by 47% in the elementary schools, but decreased in-school suspensions by 15%. Overall, suspension rates decreased at the middle school and high school level, which typically have higher rates of punitive consequences (e.g., suspensions) than elementary schools, showing positive implications for PBIS.

Since office discipline referrals are a teacher regulated process, there is room for error in regards to cultural bias, inconsistencies between externalizing and internalizing behaviors, and unrealistic expectations. Office discipline referrals are types of data that the RTI process takes into account for students needing additional supports; however, RTI also recognizes the need for supports for students who are extremely shy, withdrawn, and depressed (Gruman & Hoelzen, 2011).

Behavior modification. Once the youth exits residential treatment and integrates into the school setting, school staff should determine what types of services will best help the student. Supports available for students at an individual level are through a 504, FBA/BIP, or through the high tiers in the RTI and PBIS models. Gruman and Hoelzen (2011) discuss RTI in the school setting, but also provide several case studies for elementary-aged children from a Title I school that show how the school implemented RTI at the various levels. Referrals came from teachers and parents for issues, such as depressive symptoms, poor school performance, and/or disruptive and inattentive behaviors. Observations helped the behavior team develop a baseline for

behaviors as part of the Tier 1 process. Parents were involved in the discussion of the data and possible interventions to implement. In one of the cases, the child was having an increased difficulty even when Tier 2 interventions were in place. The parents sought out assistance from a family physician where the student received a diagnosis of ADHD and started a medication regimen. This student was on task 68% of the time versus 45%, and he returned to Tier 1 supports. A main focus of RTI is to implement strategies and interventions for struggling students before they get worse and to decrease the number of referrals to special education.

Behavior modification is beneficial across all ages and grade levels, and this section observes the behavior modification process for an elementary level boy. Levine and Anshel (2011) present a case on an 8-year-old boy with problematic behaviors associated with ADHD. The boy did not go to residential treatment for his behaviors, but the focus of the study was how his school developed a behavior management plan and utilized cognitive behavioral interventions to modify his behaviors. The treatment goals helped identify management plans at school for improving behaviors and academics, as well as, addressing inattentiveness and noncompliance at home (Levine & Anshel, 2011). Several staff completed a FBA that identified environmental aspects that may cause or precede his misbehaviors. Staff and parents utilized various techniques, such as targeted prompting, active ignoring, positive attending, and token economy. The adults also practiced cognitive restructuring and disputing their own negative or unrealistic beliefs of the student (e.g., "he's so lazy") (Levine & Anshel, 2011). The student worked on cognitive restructuring practices to improve his self-image and increase his understanding of changes occurring at school and home. Levine and Anshel (2011) discuss the importance of parents and school staff involvement for modifying behaviors of their students and children.

Special needs. Additionally, disabilities can affect the quality of life and increase problematic behavior for youth in residential settings. Trout et al. (2009) focused on a group of 123 youth of which 28% had a disability (e.g., sensory, physical, neurological, and developmental). The authors discussed some of the difficulties of disabilities, such as social skills and learning, and how the characteristics amplified in treatment facilities. The group of youth were administered several assessments: the Child Behavior Check List (CBCL) for data on behavior, the National Institute of Mental Health Diagnostic Interview Schedule for Children IV (NIMH DISC-IV) for identifying mental health concerns, and the Woodcock-Johnson Test of Achievement, third edition (WJ III) for academic aspects. The behavior and mental health assessment scores appeared elevated for both groups, but the biggest discrepancies were in academics for youth with disabilities (Trout et al., 2009). Youth with disabilities had increased difficulties with reading fluency and academic knowledge. This data is important to determine the differentiation of services necessary to meet all population needs in a residential treatment facility. Even though minor differences appeared between the two groups on the CBCL, it is important to note that both populations had increased behavior problems.

The literature review restates the importance of school personnel recognizing the diversity in their student population. By acknowledging how trauma, cultural diversity, mental health services, and supportive factors vary for student-to-student, school personnel can better empathize with some of the barriers students and their families deal with continuously and be proactive with a variety of supports. For students who are returning from treatment for mental or behavioral concerns, schools have numerous programs to help support students and the teacher. By implementing the programs with fidelity, the research supports positive changes in school in forms of discipline referrals, suspensions, learning time, and planning time.

Application

The application of this research project will be in the form of a teacher in-service, which will take approximately 60 minutes. The school counselor will lead an in-service for school staff that will or have worked with students returning from residential treatment for behavior and emotional needs. The in-service will target elementary, middle, and high school personnel since students at all ages can have behavior and emotional problems. The school counselor will show a presentation that lists the rates and costs of treatment in Alaska, strengths and struggles for youth returning to their community from treatment, and techniques that school personnel can practice (See Appendix A). Aside from a presentation, school personnel will have an opportunity to practice CBT techniques and walk through several scenarios within small groups. Lastly, school personnel will receive handouts about the materials covered, as well as one that covers the community resources in Alaska that can assist the youth and their family with the transition and the maintaining of goals in the long term (See Appendix I).

Conclusion

Youth who are returning from residential treatment for behavior and mental health needs require the ongoing support and care from the adults and individuals in their everyday lives. Multiple factors play a role in how successful and resilient a youth is post-treatment. Hair (2005) mentions the importance of family involvement during all parts of treatment, stability in placement (housing), and easy access to after care supports as components that lead towards a successful reintegration. Furthermore, school personnel at all levels should work towards increasing family involvement at school and providing numerous opportunities for families to be engaged with their child, other students and families, and school personnel. Research lacks for assisting school personnel in understanding this population, especially from a bioecological

framework that incorporates CBT techniques and practices. School staff will learn about the strengths and struggles these youth and their families face upon discharge. Additionally, school staff will recognize how their own unconscious mindsets may hinder student's ability to be successful. In order to increase student success and decrease negative external and internal behaviors, surrounding adults need to fully understand each and every youth as he or she exits from residential treatment facilities and feel knowledgeable and confident in their ability to work with this population and their families.

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Appendix A: Application Preparation

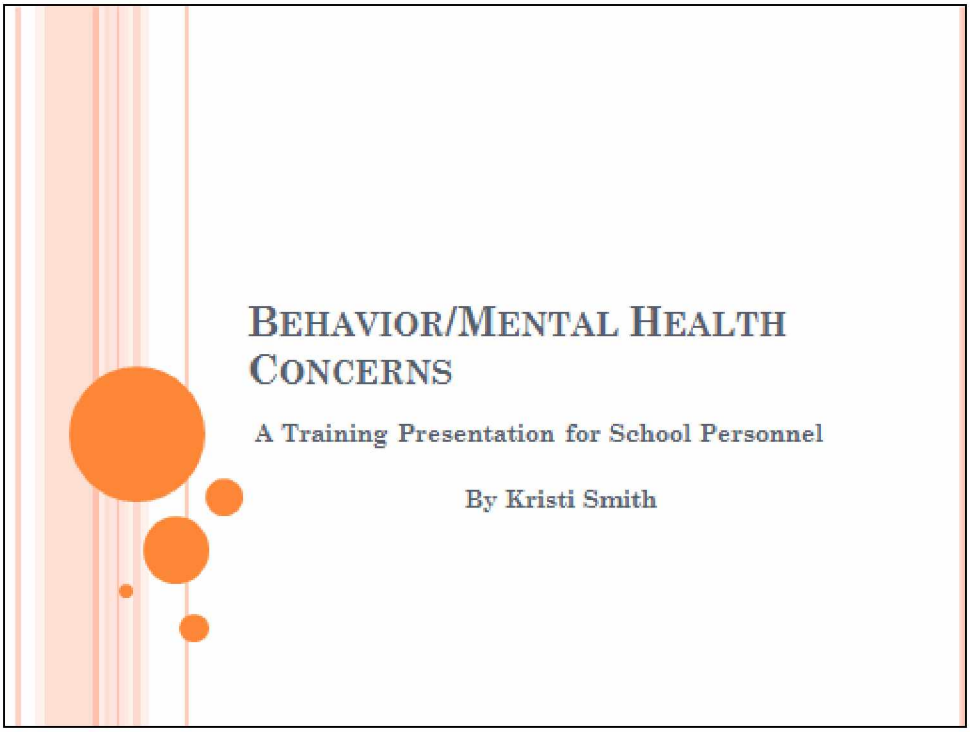
The following presentation provides school personnel the opportunity to learn more about youth with mental/behavioral health concerns who are returning to the school setting from residential treatment. School personnel will develop a better understanding about youth mental/behavioral health concerns in Alaska and how schools can best assist this transitioning population by using evidence based, schoolwide supports and individual supports. School personnel will have the opportunity to work with a small group to develop an education plan for several case studies, where their group decides what supports would best assist the student to reach academic and/or behavior goals. The last activity allows teachers to think in-depth about how they respond or react to these youth and difficult situations. School personnel practice in identifying possible negative cognitions that they either experience or ones that other personnel may have expressed. The presentation is approximately 1 hour and is applicable for elementary through high school personnel, as well as those in rural and urban locations. The setting should include places for participating school personnel to sit and easily gather with a partner or small group. It is recommended that the participants have writing utensils and something hard (e.g., table) to write on for the activities later on in the presentation.

Although much of the data and supports are part of the PowerPoint presentation, the presenter should allow some time to gather copies of the exercises, handouts, and local data that supports why this presentation is important to the school personnel. Data gathered from a local community and school level helps encourage staff to identify this dilemma and recognize the need for systemic changes. By including local data, the presentation will also increase staff buy-in to some of the schoolwide programs that are evidence based. Data gathered can include, youth treatment rates for the community or area, knowledge of mental/behavioral health agencies in the area, office discipline referrals, in-school suspensions, out-of-school suspensions,

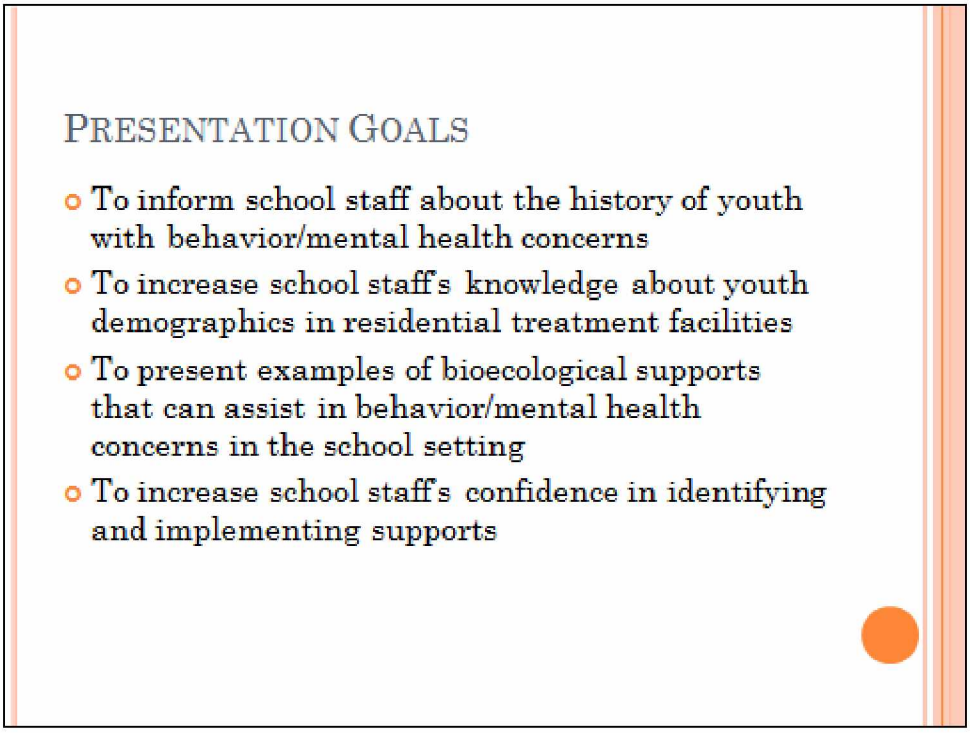
graduation rates, and attendance rates. Before the presentation, the counselor should make copies of the following handouts for each participant:

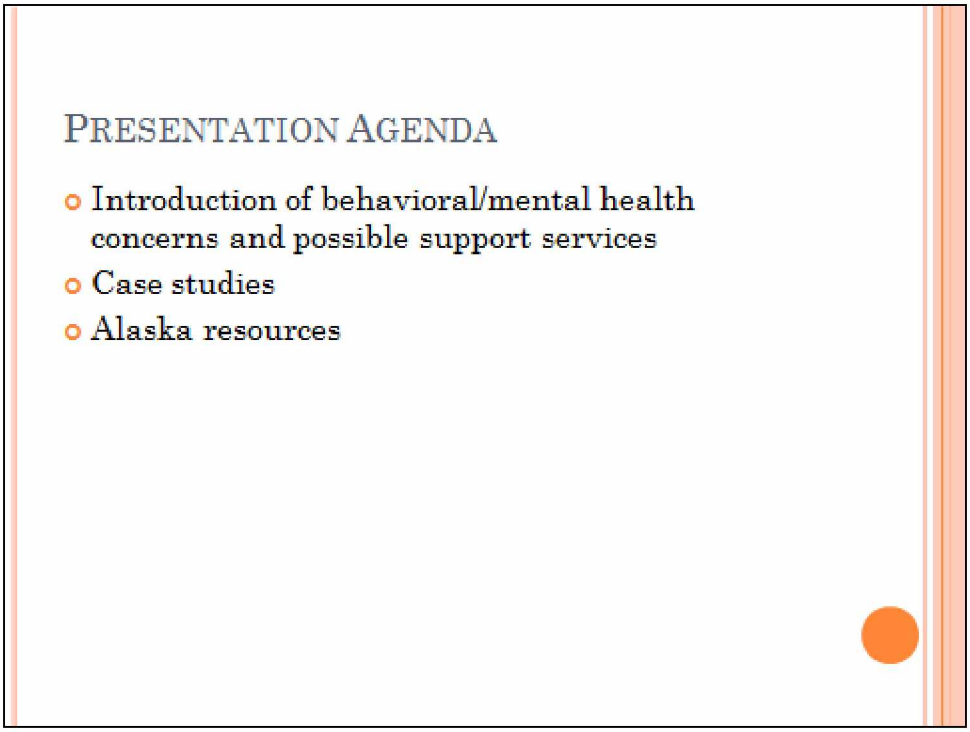
- Glossary
- IEP vs. 504
- Release of Information Forms
- Case Studies
- CBT Introduction Handout
- CBT Habits
- Community Supports in Alaska

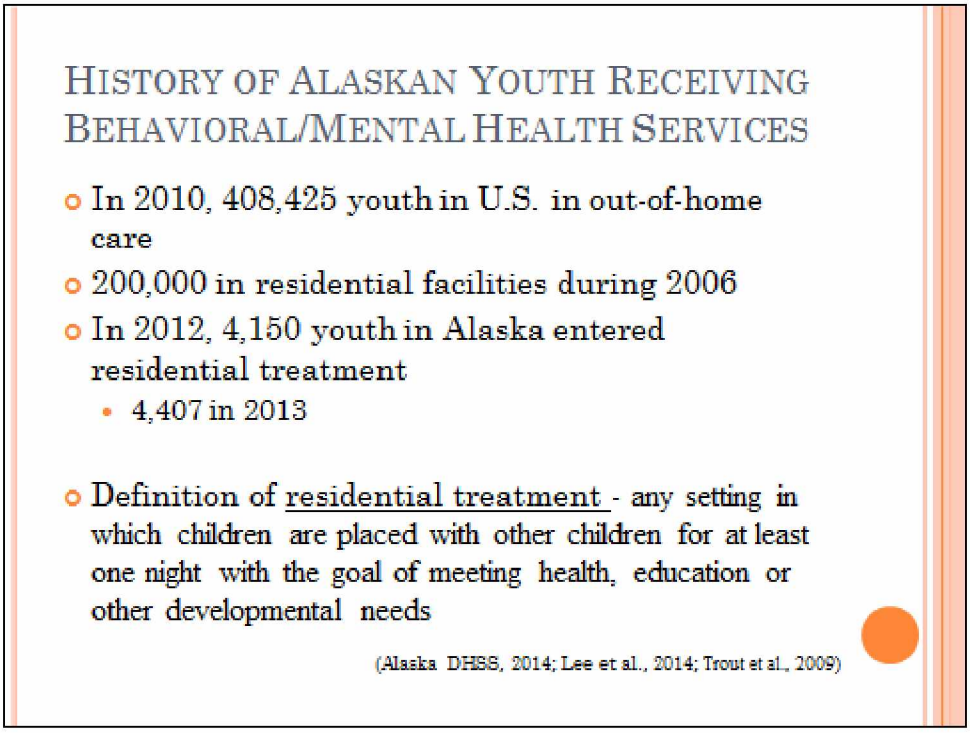
Appendix A: Presentation for School Personnel



- Welcome and thank you for being here today. This presentation targets elementary, middle, and high school personnel who work with youth with behavior and/or mental health problems.
- The number of youth in residential treatment for behavior/mental health has increased slightly over the years and these youth must eventually reintegrate into the school and community setting once they complete their treatment program.
- Schools often lack the knowledge of how to best support these students once they return to a school.
- Therefore, schools implement punitive punishments (e.g., suspensions) for student with disruptive behaviors, which can later lead to students dropping out and struggling to make ends meet.
- Many of you have experience working with youth with disruptive behaviors and/or with students who have gone to treatment for behavioral/ mental health needs.
- This presentation will help inform school personnel about this targeted population of youth as the information pertains to a brief history of treatment in Alaska for youth, environmental/personal risk factors, transition difficulties, school support programs, and building a positive school environment.

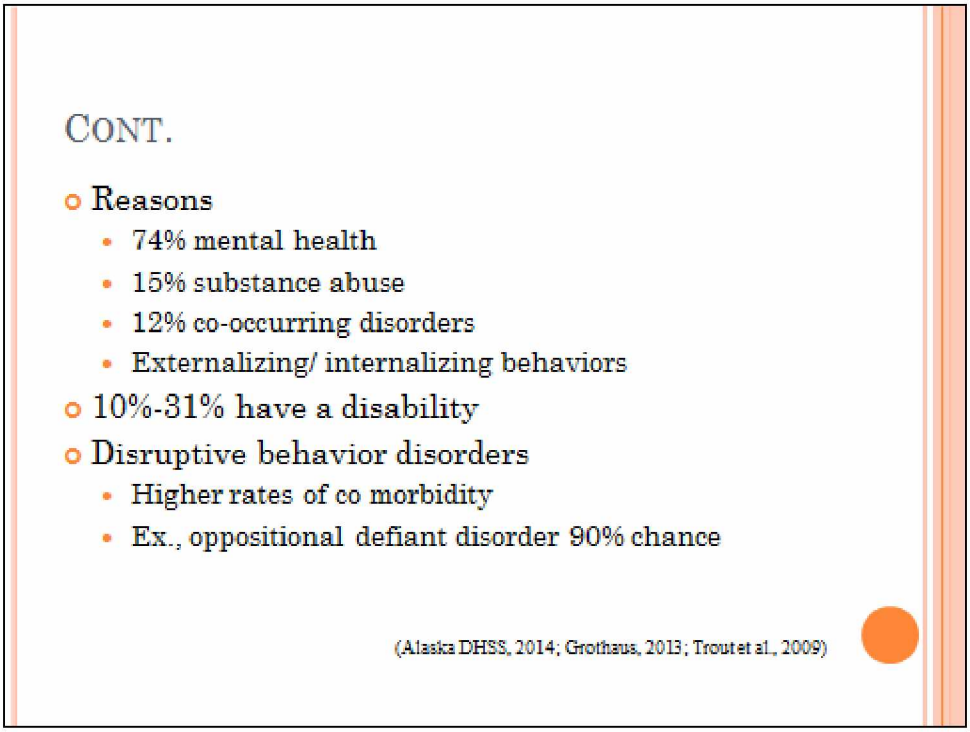

PRESENTATION GOALS
To inform school staff about the history of youth with behavior/mental health concerns
To increase school staff's knowledge about youth demographics in residential treatment facilities
To present examples of bioecological supports that can assist in behavior/mental health concerns in the school setting
To increase school staff's confidence in identifying and implementing supports


PRESENTATION AGENDA
Introduction of behavioral/mental health concerns and possible support services
Case studies
Alaska resources



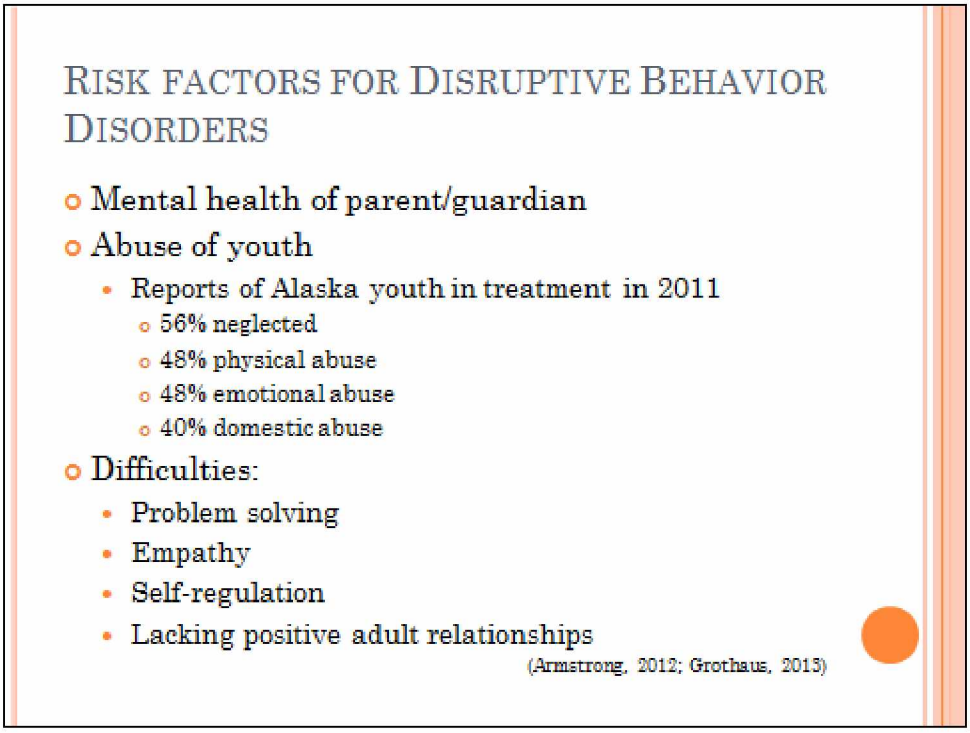
- In 2010, 408,425 youth resided in out-of-home care in the U.S. and 200,000 lived in residential facilities in 2006.
- In 2012, Alaska had approximately 2,105 children (less than age 13) and 2,045 youth (ages 13 to 18) enter treatment for mental health, substance abuse, or co-occurring disorders.
- Those numbers increased in 2013 to 2,176 for children and 2,231 for youth.
- The **definition of residence** is "any setting in which children are placed with other children for at least one night with the goal of meeting health, education or other developmental needs" (Little, Kohm, & Thompson, 2005, p. 2)

(Alaska DHSS, 2014; Lee et al., 2014; Trout et al., 2009)



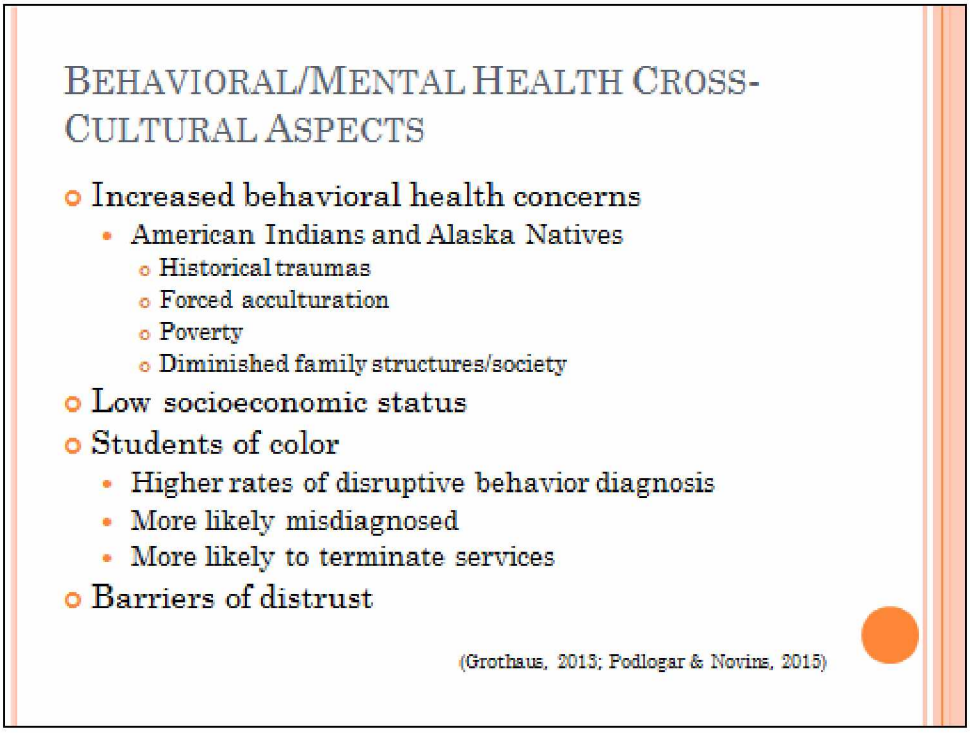
- Youth may enter treatment for various reasons and may exhibit more than one problem at once.
- Of Alaska's youth who entered treatment in the state in 2012, 74% entered for mental health concerns, 15% entered for substance abuse, and 12% entered for co-occurring disorders.
- Approximately 10% to 31% of youth in residential treatment have a disability.
- Youth with disruptive behavior disorders (DBDs) have high rates of comorbidity with other mental health issues, such as anxiety, attention-deficit/hyperactivity disorder (ADHD), and impulse control.
- Youth with oppositional defiant disorder have a 90% comorbidity rate with another mental health issue.

(Alaska DHSS, 2014; Grothaus, 2013; Trout et al., 2009)



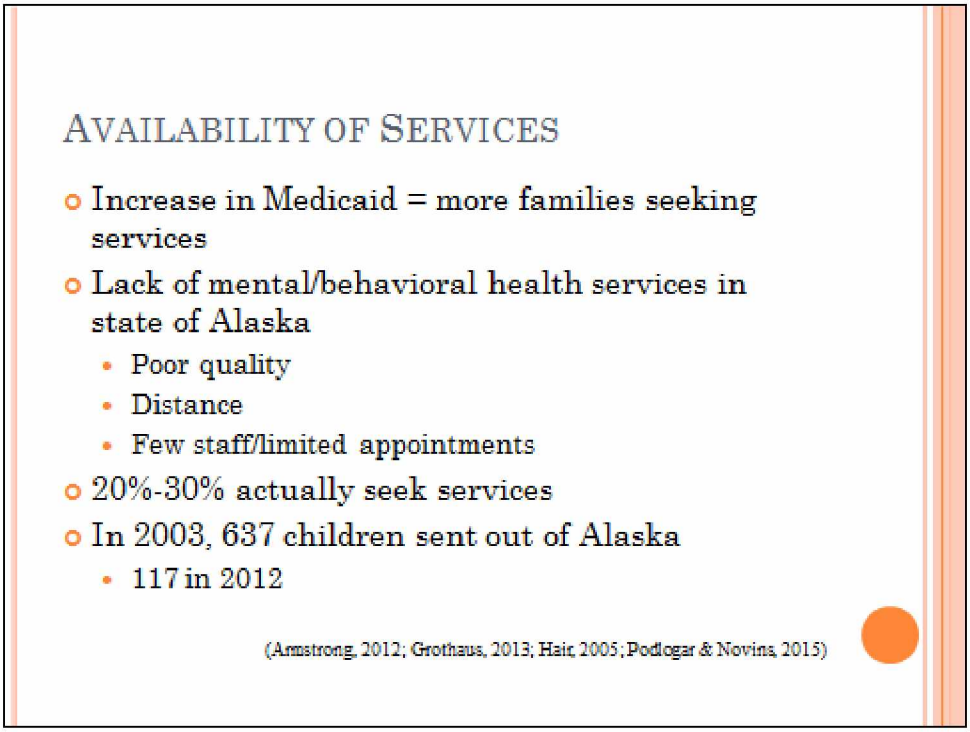
- Youth who have received a DBD diagnosis likely have a parent or guardian that struggles with at least one mental health disorder.
- Furthermore, youth who experience neglect, abuse, and family violence, for instance, may have higher risks of developing DBDs. Of Alaska youth in treatment in 2011, about 56% reported signs of neglect, 48% reported physical abuse, 48% reported emotional abuse, and 40% domestic abuse.
- They have increased rates for lacking problem solving skills, empathy, self-regulation, and positive adult relationships.

(Armstrong, 2012; Grothaus, 2013)



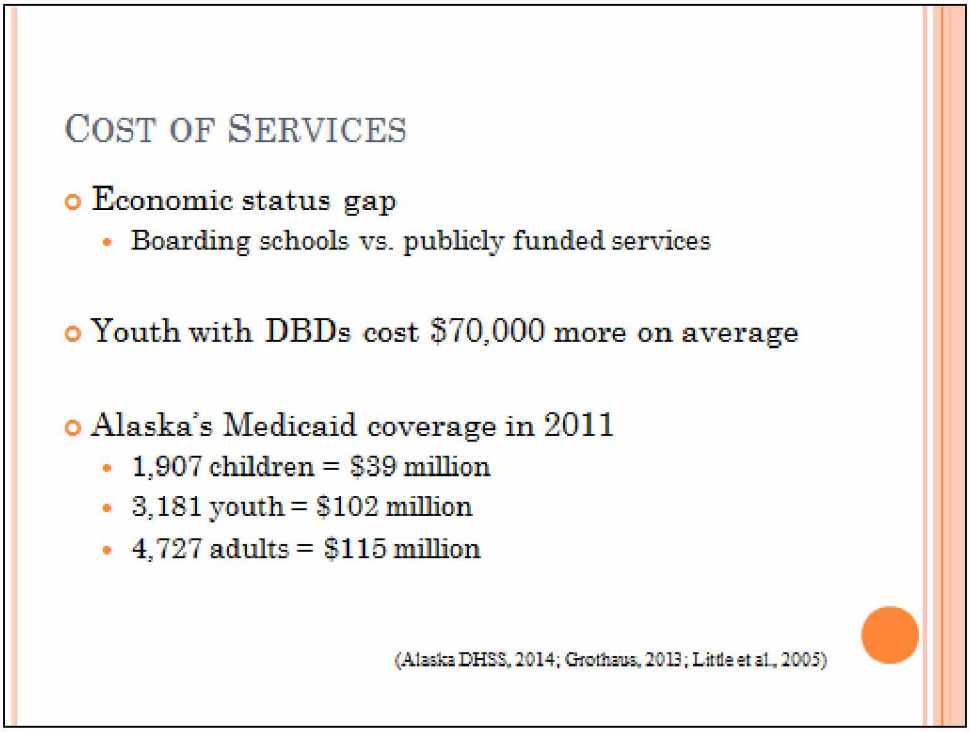
- Literature suggests that minority groups are over pathologized and diagnosed harshly compared to White people. For example, American Indians/Alaska Native people tend to have higher rates of behavioral health concerns because of historical traumas, forced acculturation into society, diminished society and family structures, poverty, and shortages of economic prospects.
- Students of color also have higher rates of disruptive behavior diagnosis than their White peers, and are more likely to be misdiagnosed. African American and Native Hawaiian youth have higher rates of DBDs, as well as those in a lower socioeconomic status.
- Students of color access mental health services less often than their White peers and have higher rates for the termination of services.
- Barriers of distrust include lack of cultural knowledge by the health professionals, perceived discrimination, and ignorance of the effect of historical traumas on American Indian/Alaska Native peoples and other people of color.

(Grothaus, 2013; Podlogar & Novins, 2015)



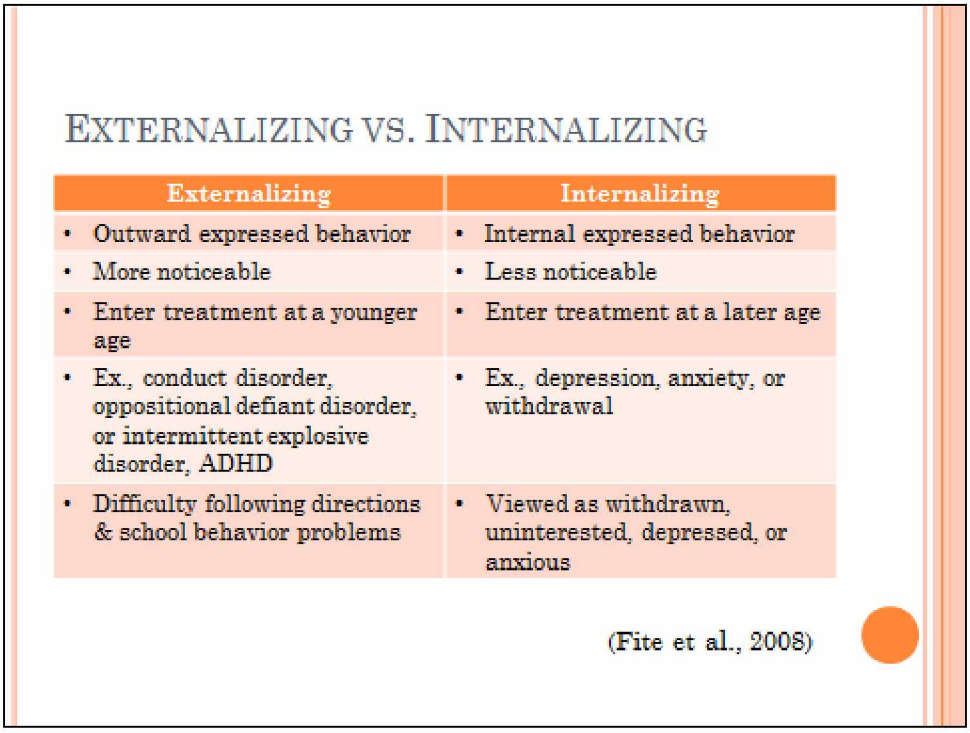
- In 1999, Medicaid funding increased and many families with youth with severe emotional/behavioral disorders sought out assistance in statewide services. However, many of these behavioral health providers' treatment strategies were grant funded and much more difficult to practice with Medicaid funds.
- The services may be poor or of unacceptable quality, lack specialized services, require traveling great distances, long waiting lines, and/or have few staff personnel or appointment options.
- Some research has shown as high as 90% of the services in clinical settings have no evidence of effectiveness.
- Only 20-30% of students needing additional mental health services actually find services in the community.
- As a result, as many as 637 children were in out-of-state residential facilities in 2003. This number has since dropped to 117 in 2012.

(Armstrong, 2012; Grothaus, 2013; Hair, 2005; Podlogar & Novins, 2015)



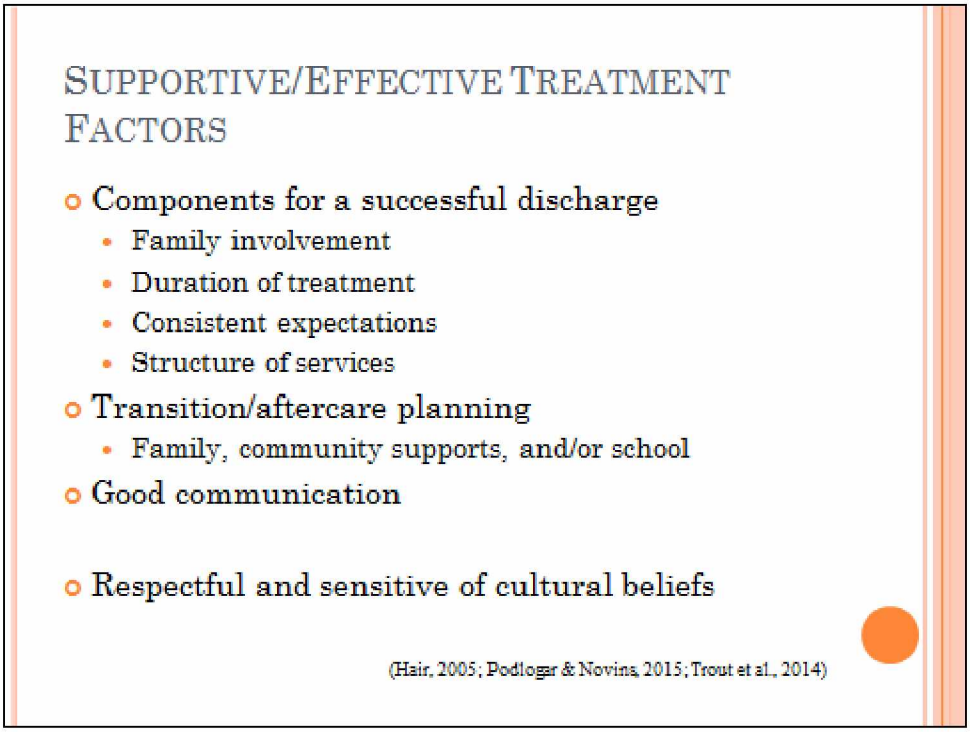
- Boarding schools are an option for families with higher income and/or private insurance who need care for children with emotional and behavioral needs and substance abuse issues. Whereas, lower income families with children exhibiting similar issues will likely need to place children in publicly funded facilities (e.g., residential treatment centers, correctional facilities).
- Additionally, youth with DBDs (e.g., conduct disorder, intermittent explosive disorder, and oppositional defiant disorder) cost an average of $70,000 more than youth without disorders.
- Alaska's Division of Behavioral Health coverage for Medicaid clients concluded that in 2011, total payments for 1,907 children cost approximately $39 million, 3,181 youth cost $102 million, and 4,727 adults cost $115 million

(Alaska DHSS, 2014; Grothaus, 2013; Little et al., 2005)



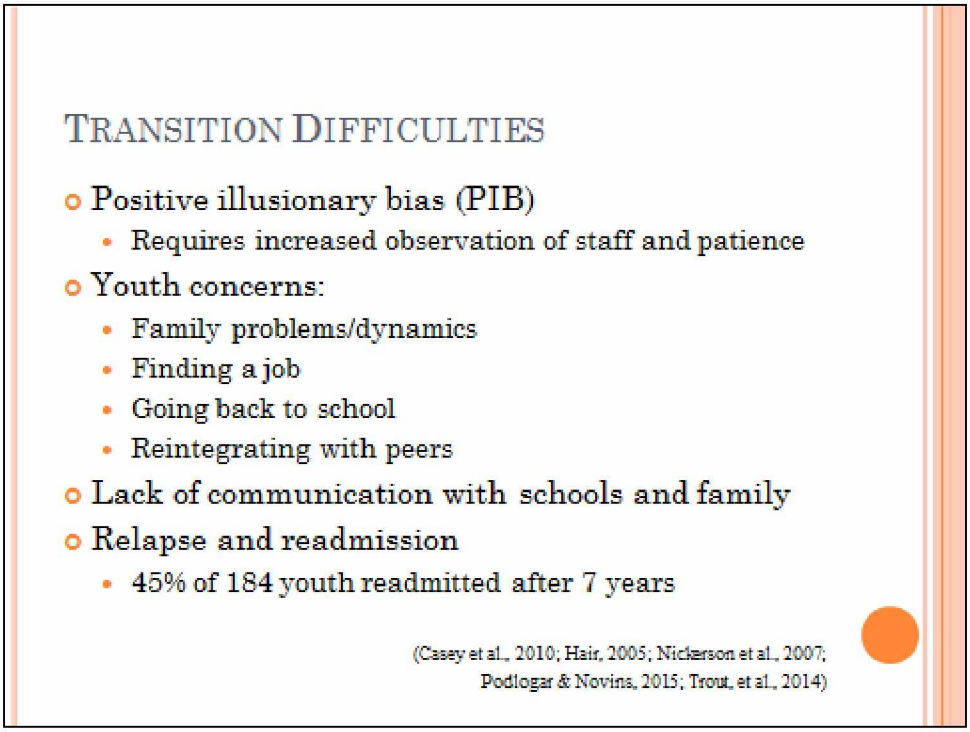
- **Externalizing behavior problems** are defined as problems that manifest in an outward behavior (e.g., conduct disorder, substance abuse) and result in the child negatively acting on his or her external environment.
- Youth exhibiting externalizing behaviors tend to enter treatment at a younger age because these behaviors frequently disrupt the surrounding environments (e.g., family, school, community).
- The younger a youth enters treatment for the first time, the more likely he or she will enter treatment as they age.
- **Internalizing behavior problems** are those that negatively impact the child's internal psychological world rather than the external environment.
- Youth with internalizing behaviors typically enter a treatment program for the first time at a slightly older age because their behaviors are unnoticed by family, friends, or teachers.
- Most families seek treatment services for externalizing behaviors; however, many youth experience co-occurring externalizing and internalizing problems.
- Youth with co-occurring problems are the largest group for outpatient services.
- A study of 372 youth in residential treatment revealed 88% have difficulty following directions and 58% have school behavior problems. Forty-five percent had feelings of depression and/or withdrawal upon admission into the residential facility.

(Fite et al., 2008)



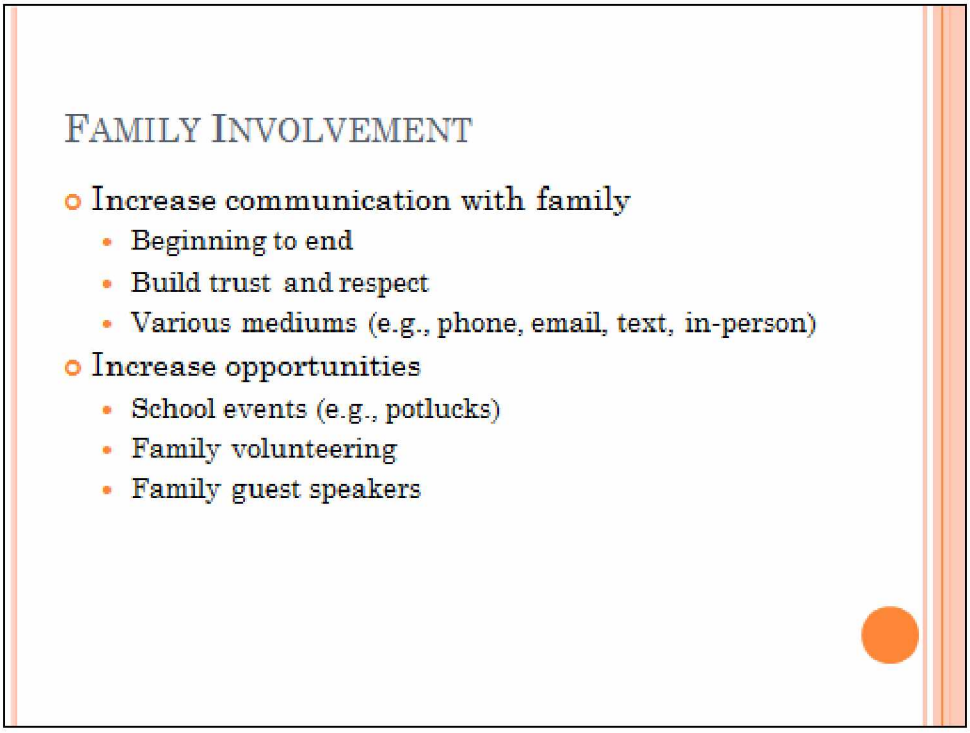
- A **successful discharge** was defined as the resident completing the program, staff felt the individual exhibited successful levels of emotional and behavioral changes, and the individual transitioned to a least restrictive, intrusive environment.
- In one study of 132 youth, 75%-80% felt a transition plan was important and they had an active role in the process. Youth felt more prepared in transitioning home that transitioning to school.
- One hundred percent of these students would like supports in areas of education, 93.8% in family, 94.7% in physical health, and 97.7% in relationships prior to their departure. Youth also ranked money management skills, developing relationships, career planning, enrolling in school, and developing homework routines and a healthy lifestyle as some of the top ten supports and services for reintegration.

(Hair, 2005; Podlogar & Novins, 2015; Trout et al., 2014)

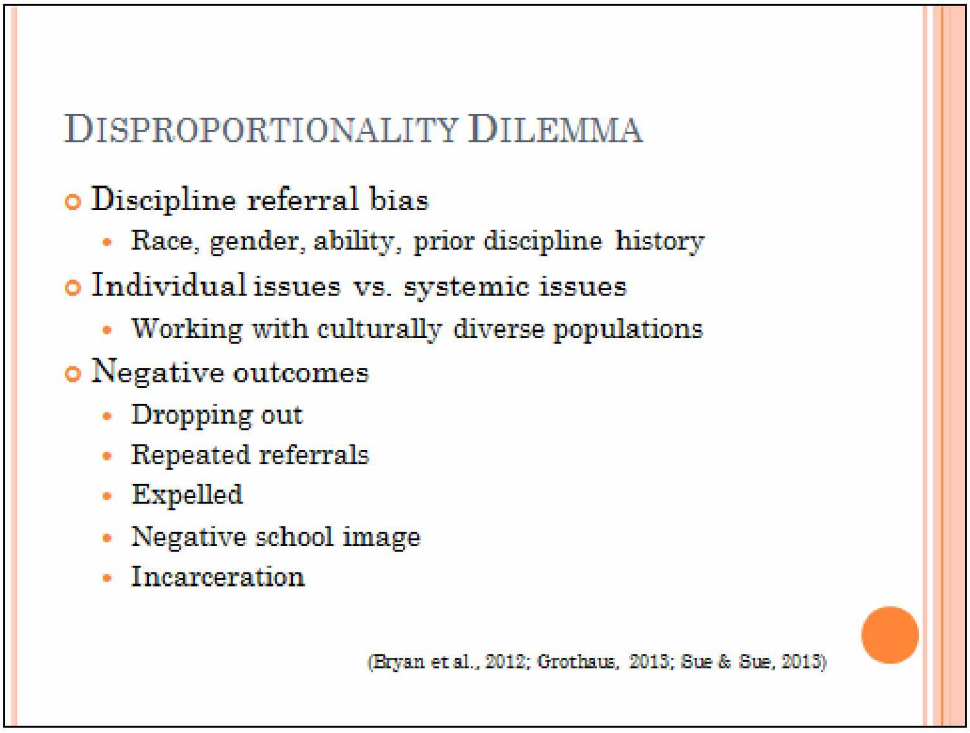


- Youth in treatment often overestimate their abilities to easily transition back into their community. This perception is known as **positive illusionary bias (PIB)** and individuals frequently exaggerate their abilities in areas of greatest difficulty. Adults need to be patient with returning youth and observant of behaviors and grades that may symbolize hidden areas of difficulty.
- Over 90% of 20 residential youth reported having a positive adult relationship, having a close friend with positive influence, and having internal strengths.
- A study of 20 youth revealed approximately 72% have family problems (e.g., abuse, domestic violence, neglect).
- Youth and parents rate **communication** between the facility and the youth's home school as highly important, yet in one study fewer than 50% of residential staff reported not keeping the youth in contact with their home school, and 58% of residential staff replied as rarely or never contacting the youth's school at post-release.
- Communication with any family is expected so the family feels part of the treatment process and lack thereof is a common reason for mistrust in service providers for American Indian and Alaska Native families.
- One study showed 45% of 184 youth **returned to treatment** by the 7-year follow up.
- The previously mentioned study of 20 students showed 42% had been arrested, 12% struggled with drug abuse, and 21% had alcohol problems upon a follow-up study.
- Even though the youth learn coping strategies and effective techniques to live a healthy lifestyle in treatment, it is increasingly difficult for youth to feel comfortable and confident with implementing these strategies at home or amongst friends.

(Casey et al., 2010; Hair, 2005; Nickerson et al., 2007; Podlogar & Novins, 2015; Trout, et al., 2014)

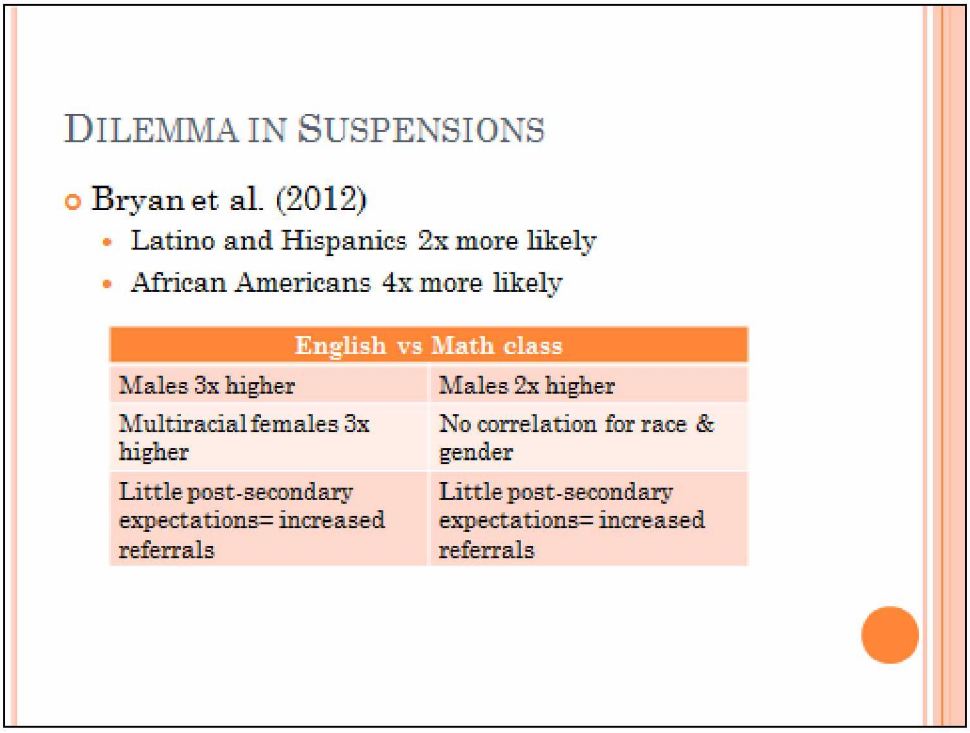


- Because studies have shown that family is such an integral part in the youth's success during treatment, it is important for school personnel to evaluate their communication with family members as a part of the post treatment and after care plan.
- If applicable, communication can start prior to the student transitioning into the school setting. If not, communication is ongoing from the day of re-entry.
- Communication builds trust between the family and school personnel and allows for opportunities for questions and/or concerns to be voiced.
- Family members may have certain communication styles that work best for them (e.g., phone, email, text, in-person).
- Schools can work toward increasing the family involvement in the school setting by planning events and opportunities throughout the year.



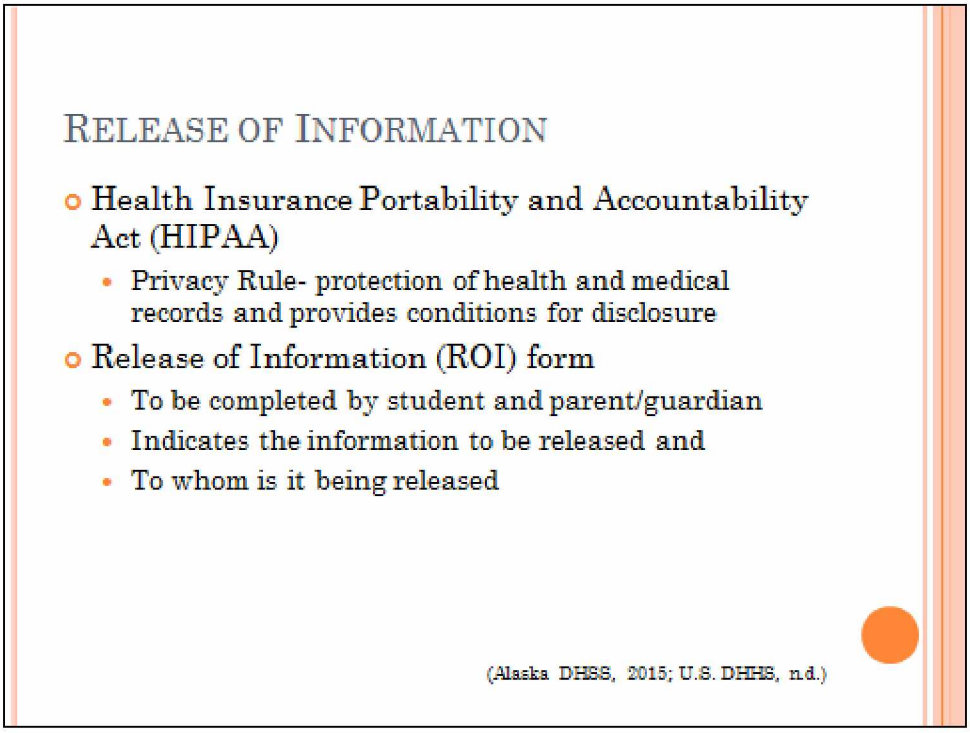
- Suspensions and behavior referrals to school administration and school counselors can be biased depending on the student's race, gender, and previous discipline referrals.
- Students with previous discipline referrals have a tendency for increased supervision during the school day and may get in trouble for minor issues in comparison to their peers.
- It is easier for schools to blame the individual for their inability to be successful at school, rather than look at the systemic issues that are supported by school and social environment.
- Research supports that suspensions, repeated referrals, and expulsions are detrimental to the youth because they lead to further disengagement from the school environment, negative image of school, dropping out, and incarceration.

(Bryan et al., 2012; Grothaus, 2013; Sue & Sue, 2013)



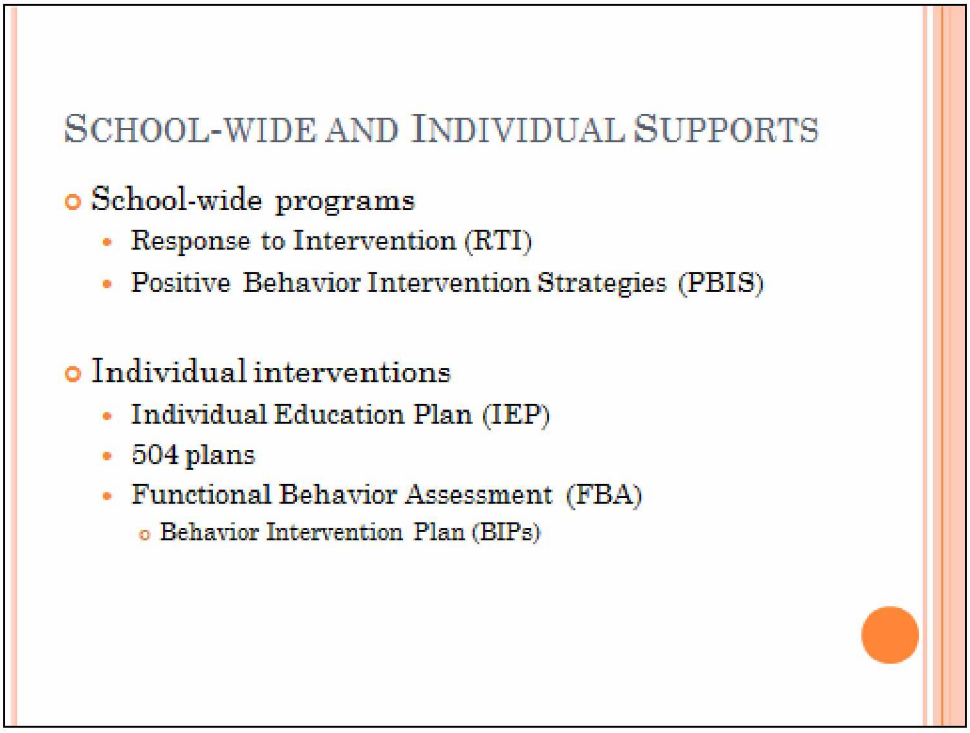
- Acknowledged by the National Center for Education Statistics (NCES), Latino and African American students face twice as many school suspensions in comparison with White students.
- Hispanic people are twice as likely and African American people four times more likely to be suspended than their White peers.
- One study showed males were three times more likely to be referred to school counselors than females in an English class, as well as, multiracial females were three times as likely to receive referrals.
- The NCES summary states that math and English teachers referred students whom they felt had little post-secondary expectations more frequently than others.

- This is a summary of the areas of support for transitioning youth. Studies have shown youth identified these areas as areas they would like addition support during their transition. Even though schools see students after the fact, youth should continue to research assistance in these areas.

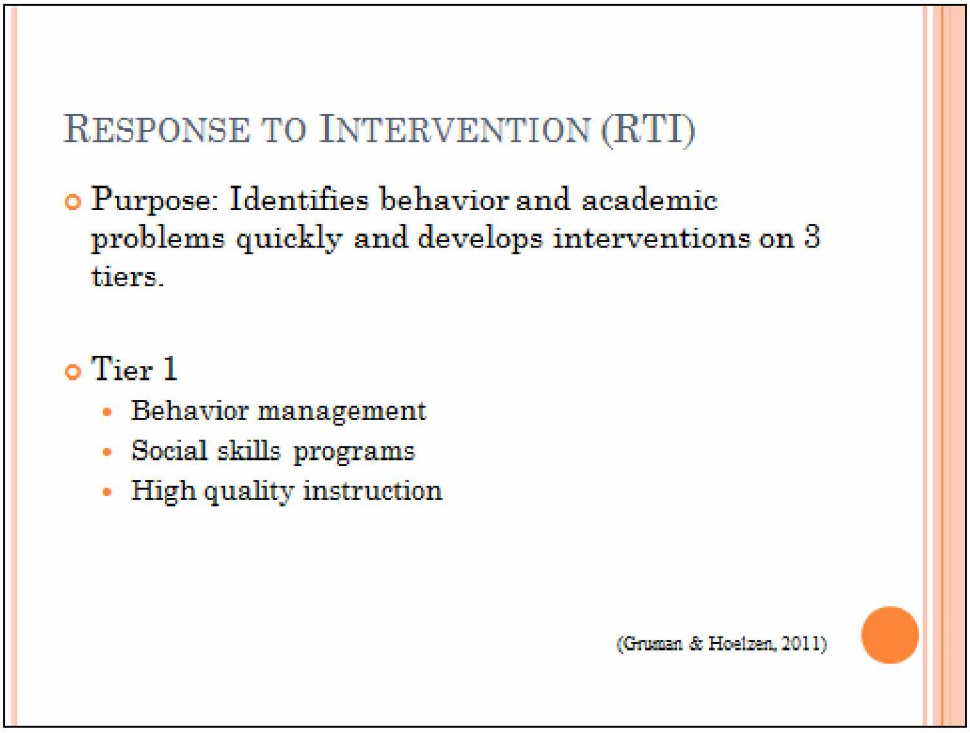


- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule ensures privacy of an individual's health and medical records through national standards.
- The Privacy Rule national standard establishes the conditions and limits to which client private health information is disclosed to other parties per the patient's request.
- In order for school personnel to receive a student's treatment information, the student and parent or guardian must complete an authorization form or release of information (ROI) that permits selected health information to be released to the school.
- See handout for examples.

(Alaska DHSS, 2015; U.S. DHHS, n.d.)

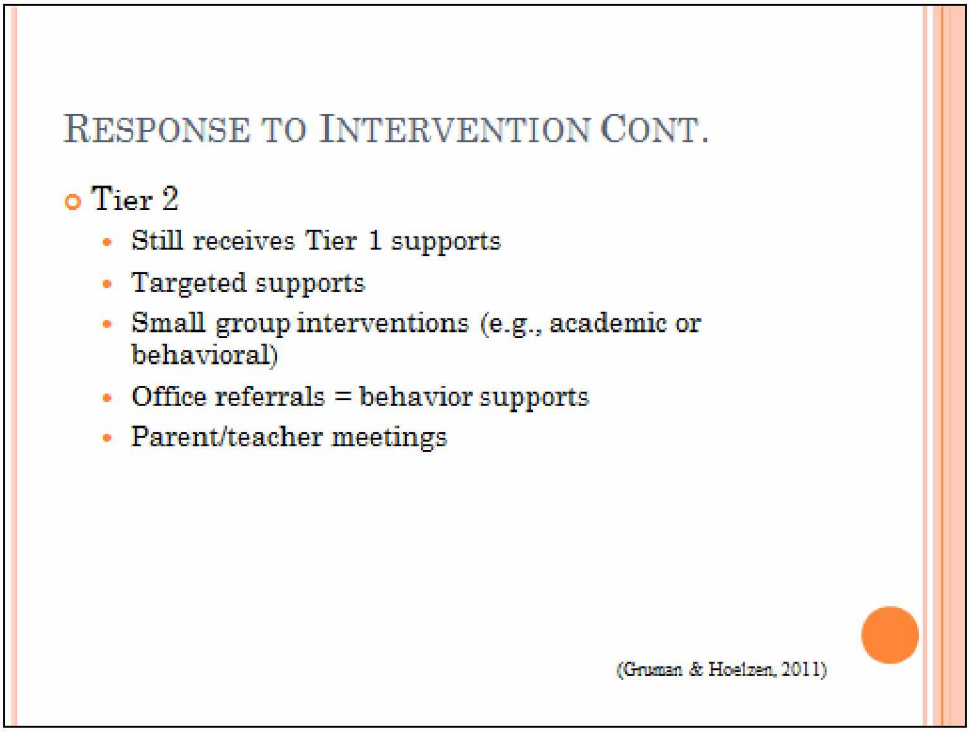


- This section introduces supports and interventions available at a school-wide level and individual level once students enter the school system.
- Each school needs to be mindful of how the services can be applicable with diverse populations.



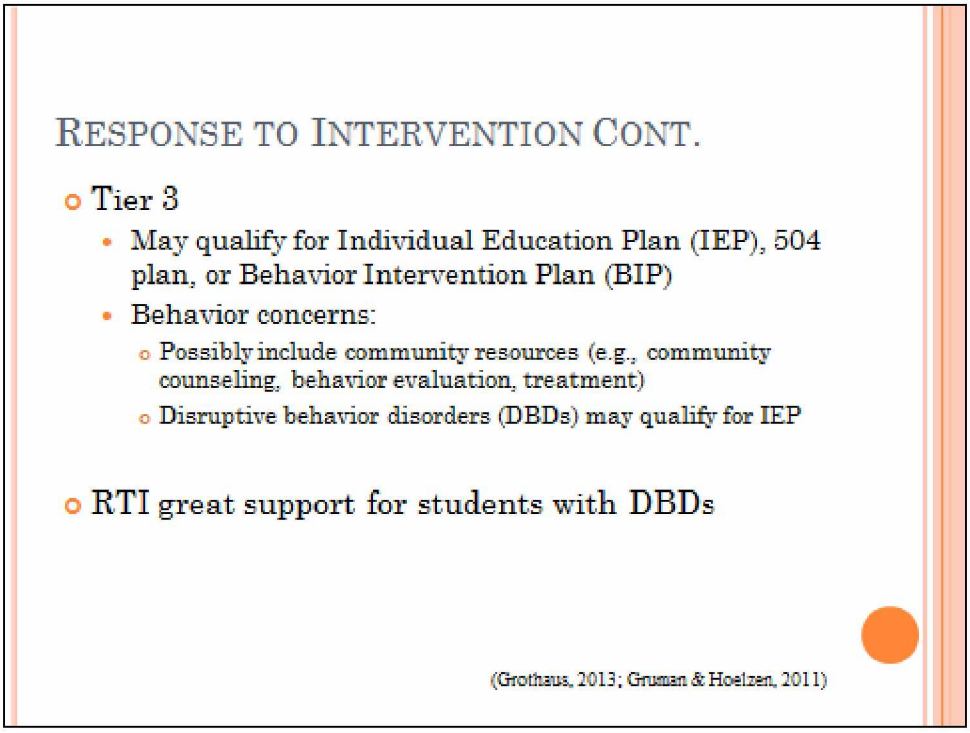
- At Tier 1, counselors may collaborate with teachers on engagement strategies, transition programs for new students, and school wide conflict management.

(Gruman & Hoelzen, 2011)



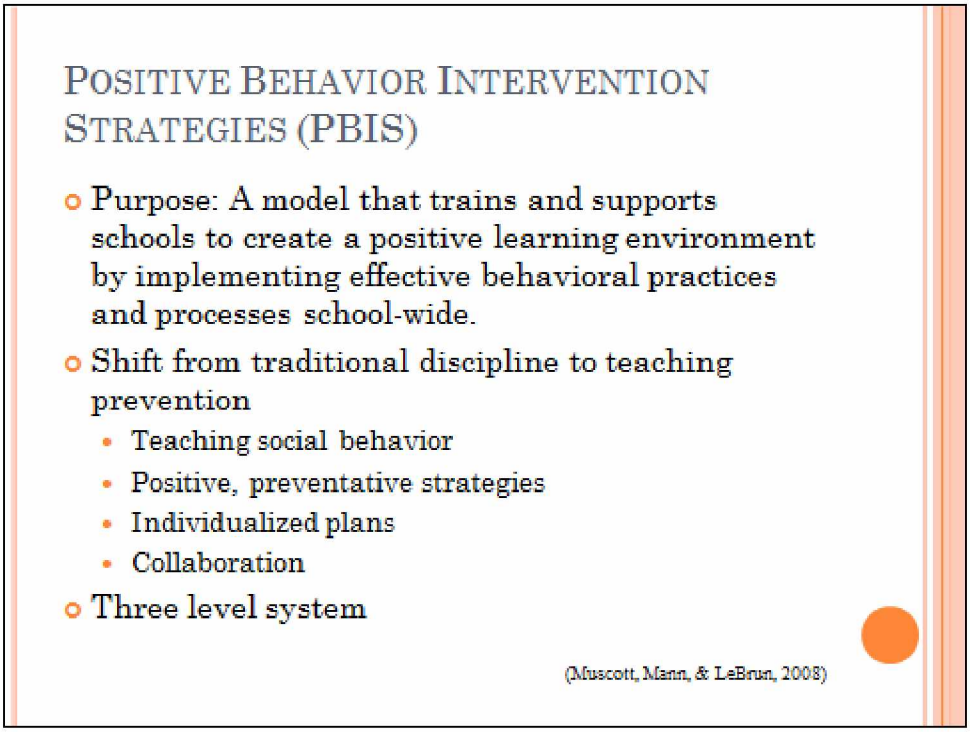
- If Tier 2 interventions are being considered, the counselor gathers student data from the student's cumulative file, assessment scores, previous meetings with the teacher and student, and observations.
- Students at Tier 2 still receive the supports from Tier 1 in addition to more targeted supports.
- At this level, the student may receive **small group interventions** for academic and/or behavioral difficulties.
    - Academically, the student may receive small group instruction for math or reading.
    - Behaviorally, the counselor would lead a small group of students in topics regarding difficulties with social skills and behavior management. Office referrals are often used by school counselors to decide which students may need Tier 2 supports.
- School counselors may also coordinate meetings with parents and teachers to align goals or discuss mentoring programs.
- If the student shows improvements with Tier 2 interventions and has achieved behavioral and/or academic goals, the student may return to Tier 1.

(Gruman & Hoelzen, 2011)



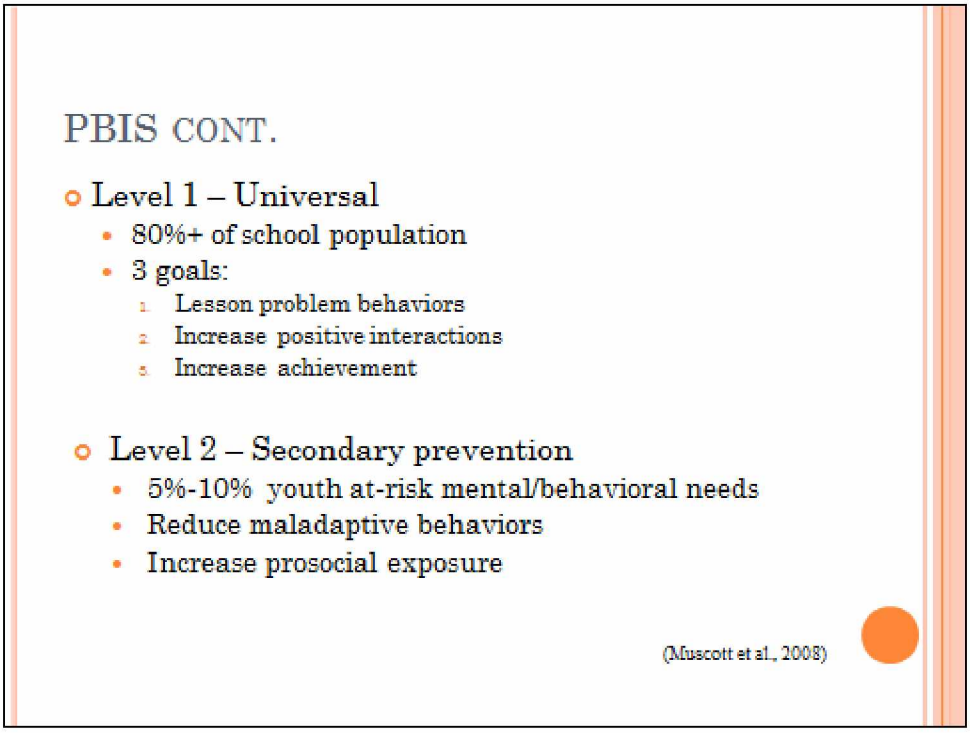
- If a student's progress were not improving with Tier 2 supports, the student would then move to individualized interventions in Tier 3.
- Students in Tier 3 with **academic concerns** may qualify for Individual Education Plans through the special education team. For those students with **behavioral concerns** in Tier 3, school counselors may look at individual counseling, 504 plans, behavior management plans, and supports from community resources (e.g., mental health counseling, behavior evaluations, or forms of treatment).
- Students with DBDs who do qualify for special education supports typically fall under an emotional disturbance category.

(Grothaus, 2013; Gruman & Hoelzen, 2011)



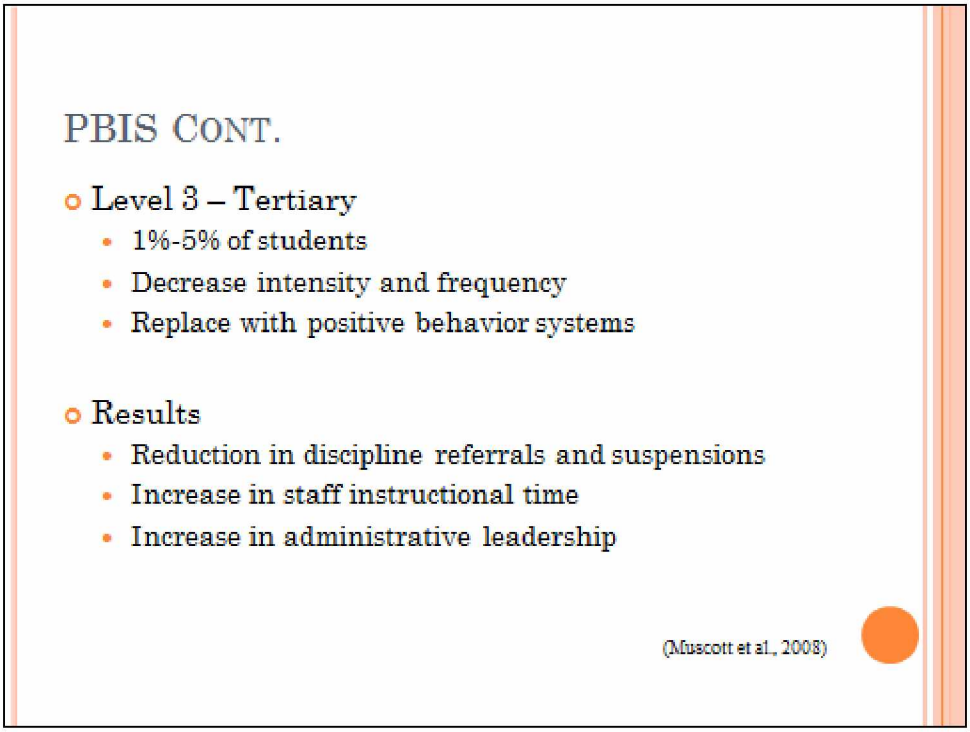
- PBIS requires a five tiered change system that trains and supports schools to create positive learning environments by implementing effective behavioral practices and processes school wide.
- The program focuses on shifting school behavior management processes from traditional punitive measures (e.g., office referrals, suspensions) to teaching positive, appropriate behaviors through three levels of prevention.
- This includes teaching social behavior, emphasizing positive and preventative strategies, creating individualized strategies for students with intensive needs, collaborating with families and community members.

(Muscott, Mann, & LeBrun, 2008)



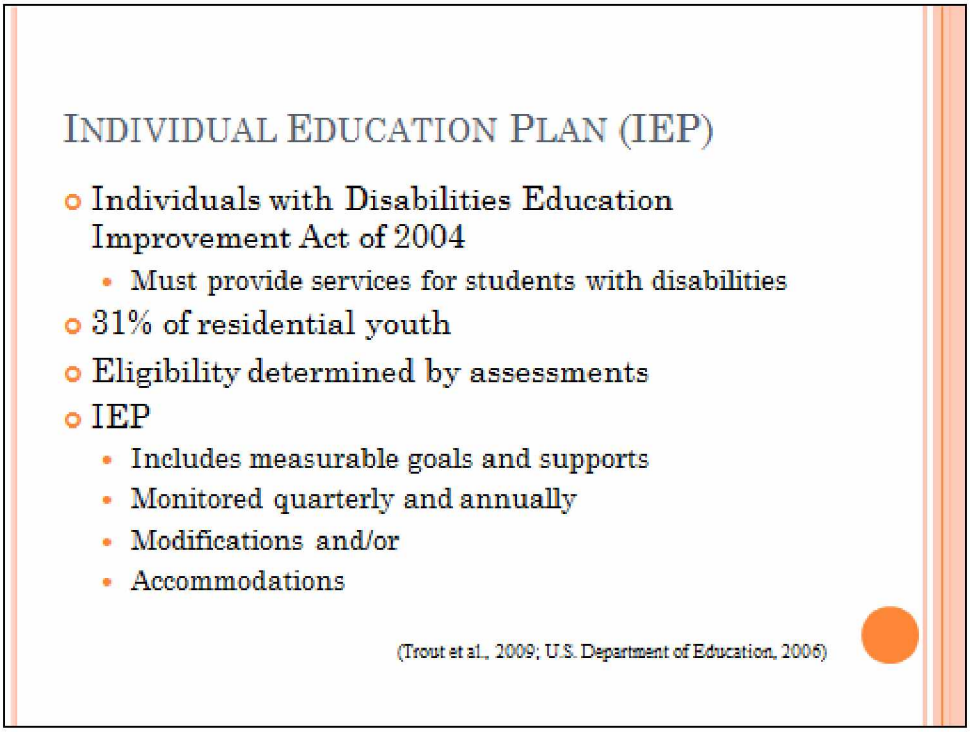
- The **first level** is universal prevention that focuses on at least 80% of the school population to learn strategies that lessen problem behaviors, increase positive interactions with peers and adults, and increase achievement.
- The **secondary stage** focuses on approximately 5%-10% of youth at-risk for behavior or mental health needs.
- PBIS would assist by reducing the opportunities for maladaptive behaviors to occur and increasing exposure to prosocial systems.

(Muscott et al., 2008)



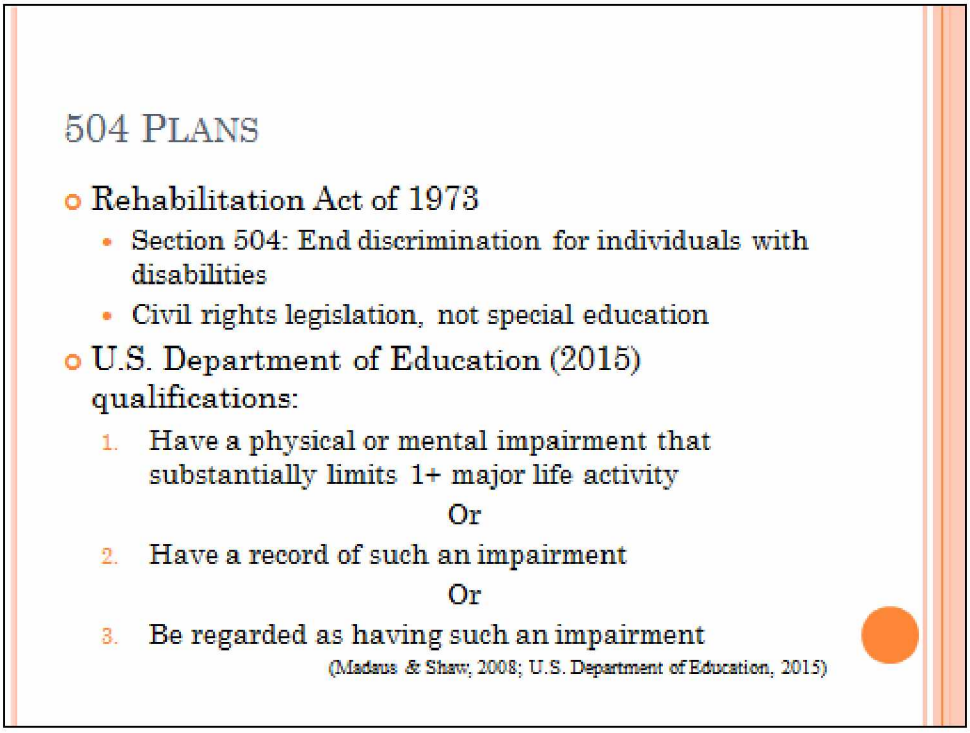
- The tertiary stage focuses on 1% to 5% of students with behavior or mental health concerns.
- This stage works towards reducing the frequency and intensity of problematic behaviors and replacing them with positive behavior systems.
- A study that included 28 K-12 schools, 38,000 youth, in New Hampshire showed 22 schools reduced office discipline referrals by 28%, or 6,010, and/or reduced in-school suspensions by 637 or 31% and out-of-school suspensions by 395 or 19%. Teachers recovered 864 days of teaching, students gained 1,701 days of education, and administration gained 571 days of leadership.

(Muscott et al., 2008)



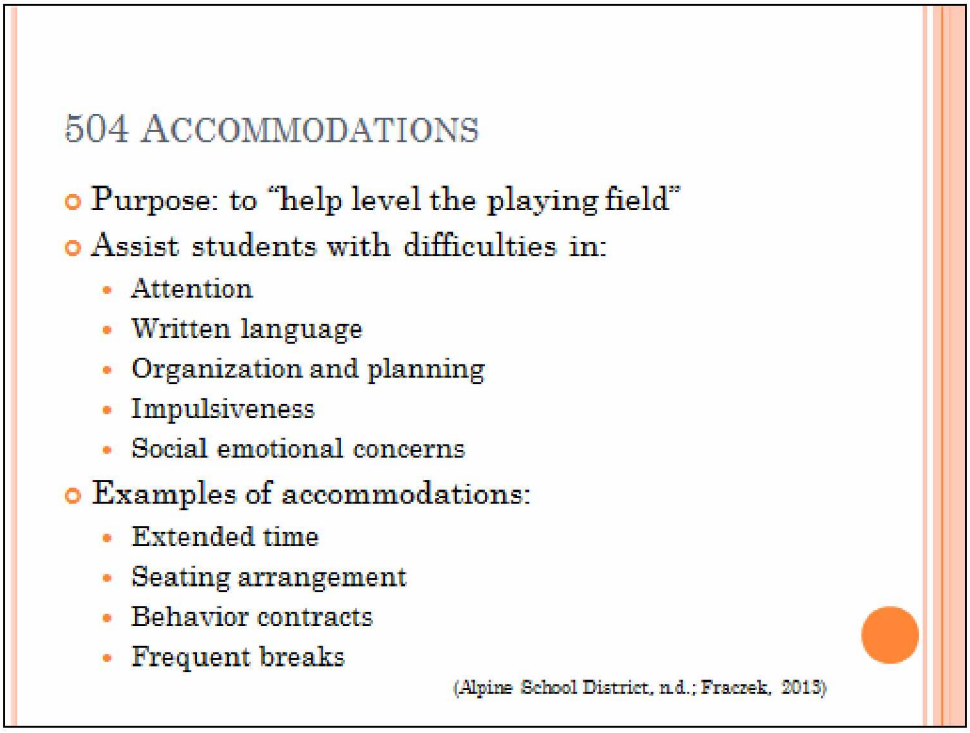
- Through the Individuals with Disabilities Education Improvement Act of 2004, schools must provide a list of mandated services to students with disabilities.
- Up to 31% of youth in residential treatment have a learning disability.
- The youth will undergo several assessments that will identify any academic or functional performance discrepancies.
- Students who qualify as having a disability receive an Individual Education Plan (IEP) that will list measureable goals and supports that will assist the student to make academic progress.
- A student's progress toward the goals is monitored quarterly and annually.
- To help achieve some of the goals, the IEP often includes **modifications** of the academic work, as well as, **accommodations** that include supplementary aids to assist in academics.

(Trout et al., 2009; U.S. Department of Education, 2006)



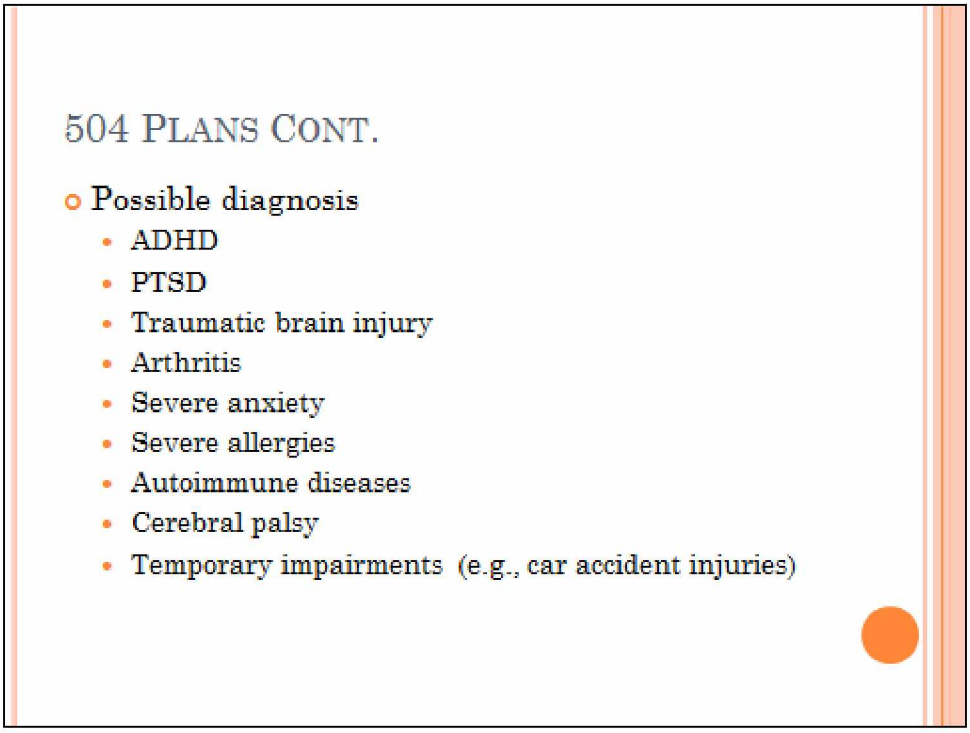
- Section 504 of the Rehabilitation Act of 1973 was established to end discrimination towards disabled individuals in any facilities or activities that receive funding from the federal government.
- Schools were in compliance with IDEA and assumed that all students with disabilities were supported under IDEA, but that was not true. Not all students with disabilities were covered under IDEA.
- In order to qualify for a 504 plan, the student must have a physical or mental impairment that substantially limits one or more major activity, have a record of such an impairment, or be regarded as having such an impairment.
- During this time, allow a moment for school personnel to look at the handout that differentiates between 504 plans and IEPs.

(Madaus & Shaw, 2008; U.S. Department of Education, 2015)

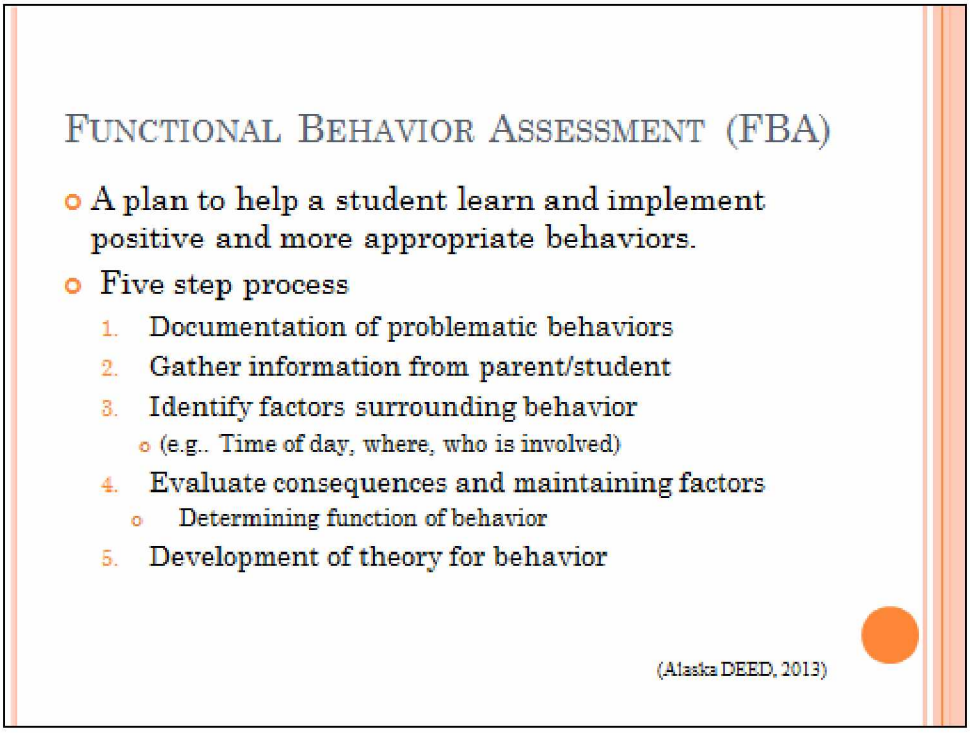


- Accommodation supports can help to "level the playing field" and remove the barriers that may prevent a student with disabilities equal access to education and extracurricular activities.
- Accommodations can help students in difficulties with attention, written language, organization and planning, impulsiveness, and social emotional concerns.
- Some examples of accommodations are time extension for assignments and assessments, placement of the child's seat in the classroom, behavior contracts, and frequent breaks.

(Alpine School District, n.d.; Fraczek, 2013)

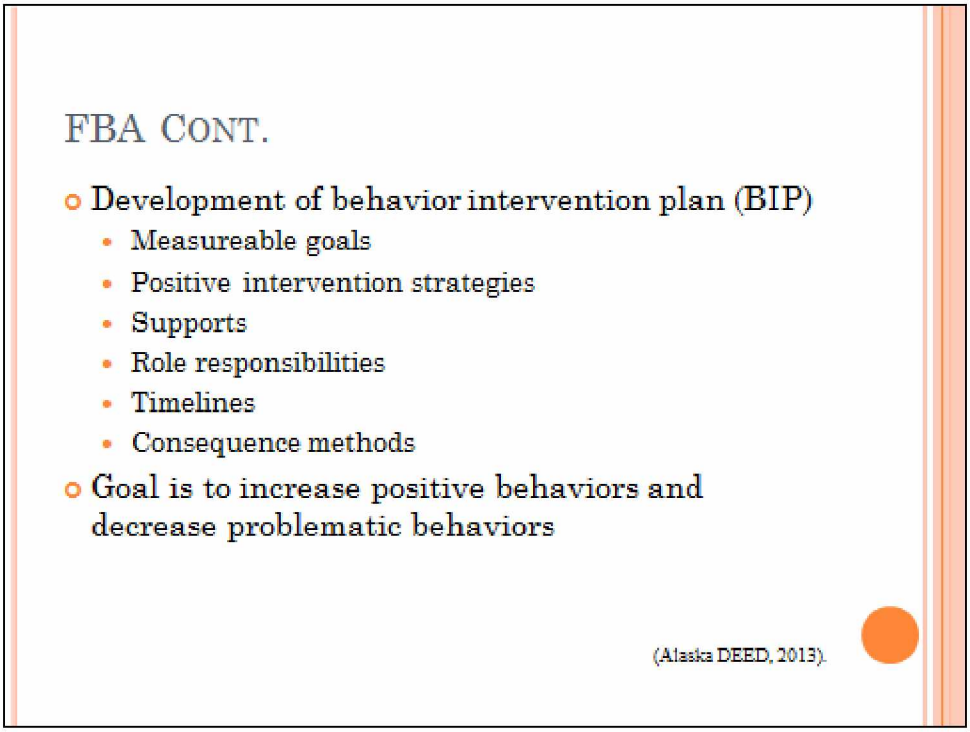


- Some diagnosis that could obtain 504 supports include, students with attention deficit/hyperactivity disorder (AD/HD), post-traumatic stress disorder (PTSD), traumatic brain injury, arthritis, autoimmune diseases, severe allergies, cerebral palsy, or temporary impairments (e.g., injuries sustained in a car accident).



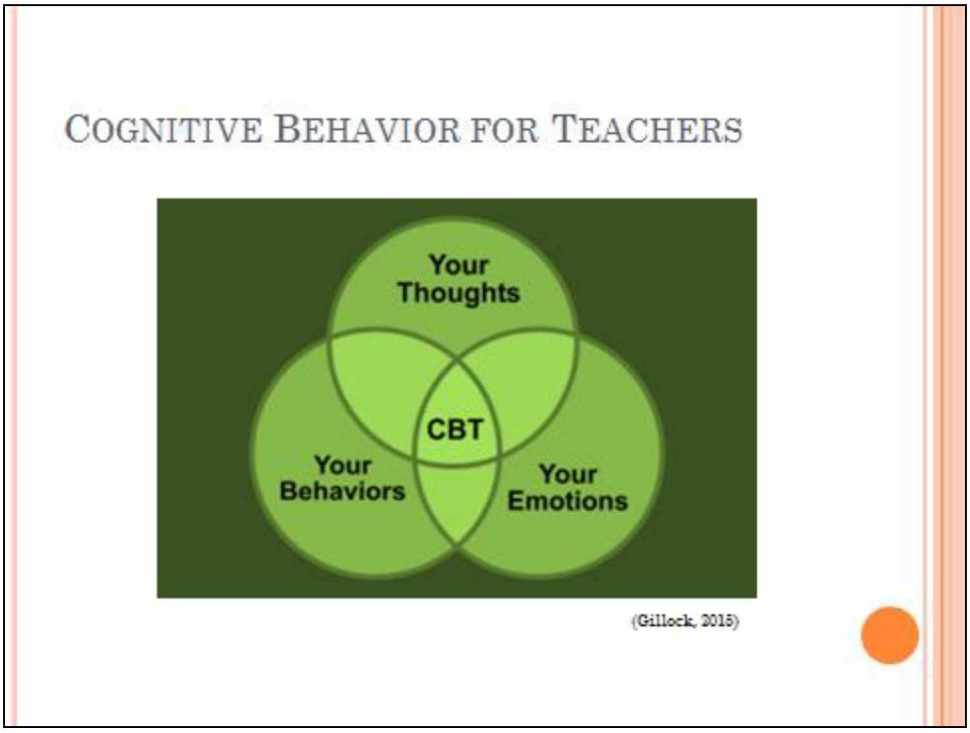
- A **functional behavior assessment (FBA)** assists school staff with identifying the dynamics of a student's behavior through problem solving. Parents, educators, and agency personnel work together to design a plan that will help the student learn and implement positive and more appropriate behaviors.
- **Step one**. Those involved with the student document the behaviors of most concern and provide descriptions of the problem behaviors.
- **Step two**. Additional information is gathered from the student and parent, such as medical, physical, routines, prior stressful events, and any history of abuse. The team can process to see if any of the information learned may be related to the school behaviors.
- **Step three**. The team goes more in depth as to break down the situation where the observed behavior occur. This stage helps to predict when the targeted behavior may occur. Results, for instance, will identify what the student may be seeking (e.g., attention, avoiding schoolwork).
- **Step four**. Fourth, the team moves toward understanding the consequences in place and maintaining factors of the behavior (e.g., how are students and the adults responding to the behavior? Is the student likely to stop or proceed with the behavior?). This step helps to determine the function or maintaining factors for the targeted behavior.
- **Step five.** The fifth step develops a theory that uses data from the previous steps to help determine why or how a student engages in the identified problematic behavior. The team will have a general idea as to what the behavior looks like, the setting in which it occurs, and outcomes that may maintain the behavior.

(Alaska DEED, 2013)



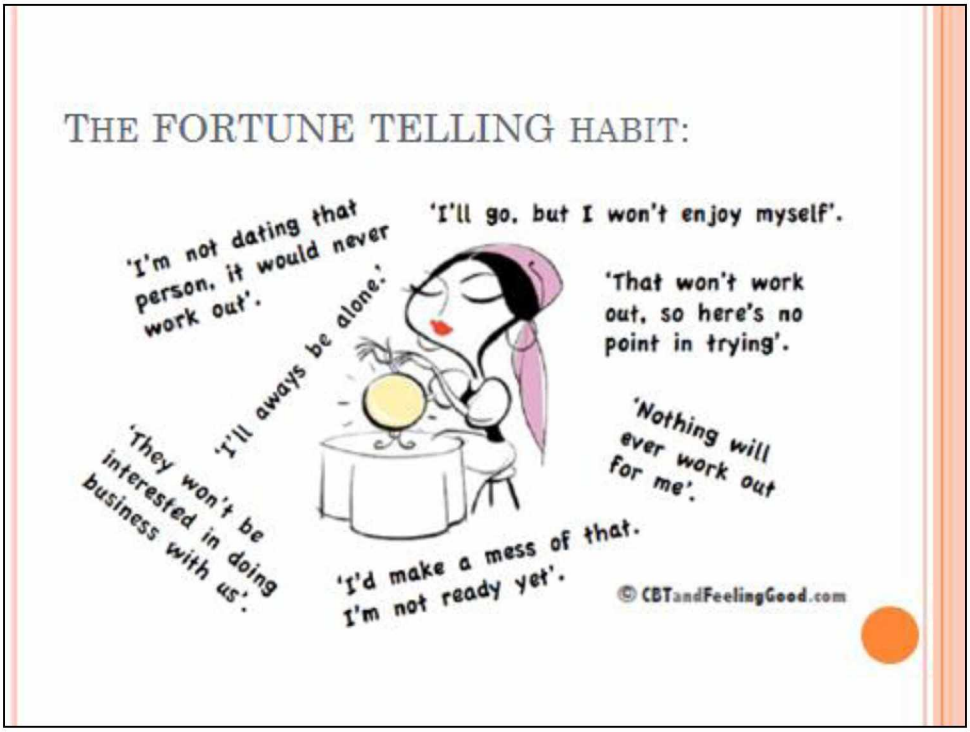
- Once an FBA has been completed, the team will design a behavior intervention plan (BIP) that lists the positive intervention strategies, supports, role responsibilities, timelines, and consequence methods. The BIP includes ongoing data tracking and support for the measurable goals that will help to increase positive behaviors and decrease problematic behaviors.
- Have school personnel pair up or gather in small groups to work through some of the case studies. Pass out the case studies handout. With the knowledge gathered, ask school personnel to develop a plan for that case study and be ready to present it to the group.

(Alaska DEED, 2013)



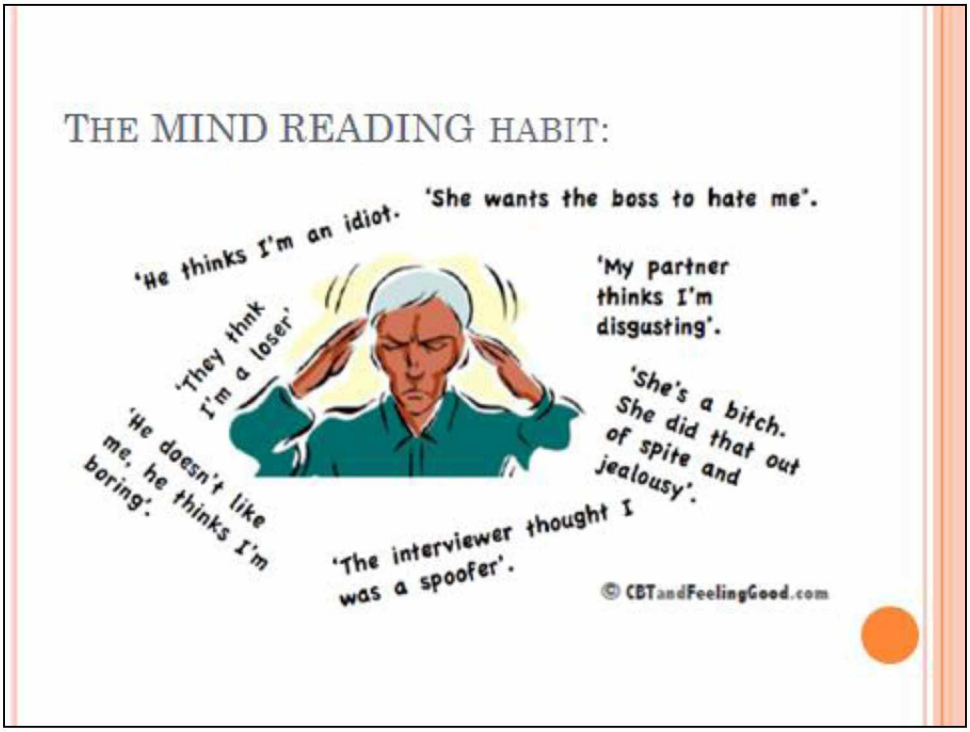
- In this section, we'll be discussing some common CBT habits that we as adults may have in our work environment with our colleagues and students.
- External behaviors determine internal thought processes. Individuals can form negative cognitive distortions or maladaptive thoughts that influence how they perceive their surroundings. CBT helps to relieve emotional distress when working with students exhibiting difficult behaviors. Staff is encouraged to unconditionally accept themselves and their students and understand that people make mistakes and have flaws, but may still be an overall good person.
- CBT can help teachers cognitively reframe their negative thoughts towards youth with behavior issues in the classroom or school setting.
- Examples: 1) When a teacher has high expectations for a student, the student is more frequently called upon, and may receive more forms of encouragement, 2) Students show increased levels of achievement, revealing that teacher's perceptions of students can negatively or positively influence the student's level of achievement.
- This cognitive, ecological model identifies the main student problem behaviors that emerge are learned through socialization, maintained overtime, and shaped through observational learning experiences.
- Look at the CBT Introduction Handout
- We will refer to CBT Habits (See handout) for everyone to follow along with as we go through 6 habits. I define the habit and then provide some examples. We will take a moment for you to write in your own example for each of the habits.

(Guerra, Boxer, & Kim, 2005; Kottler & Shepard, 2011; Levine & Anshel, 2011)



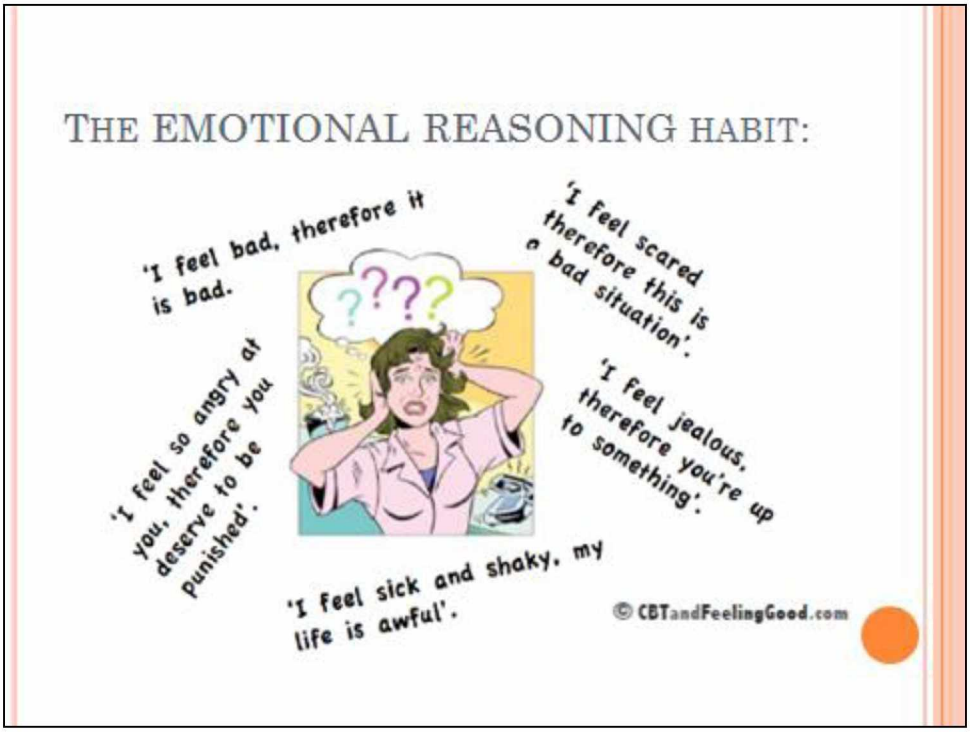
- See handout
- This habit is predicting negative outcomes for situations and events.
- Absolute statements = unrealistic thinking
- Prevents the individual from taking risks and engaging in opportunities that may lead to happiness or excitement
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)



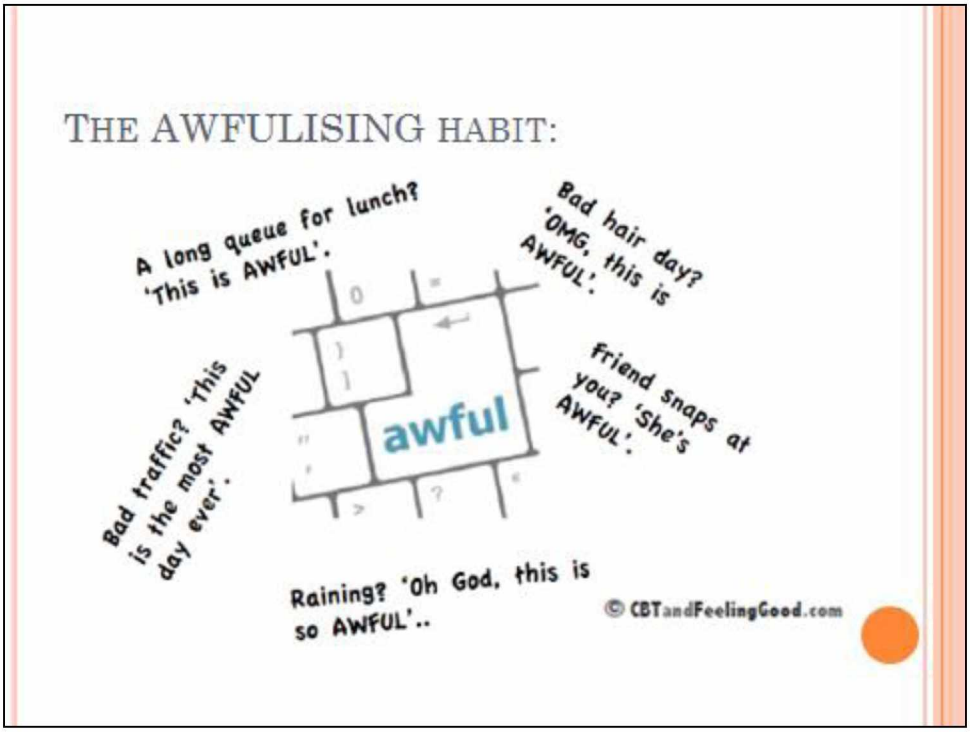
- See handout
- We cannot make assumptions as to how someone is feeling or thinking.
- These are our thoughts, not theirs.
- Practice stopping your thoughts and reframing them.
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)



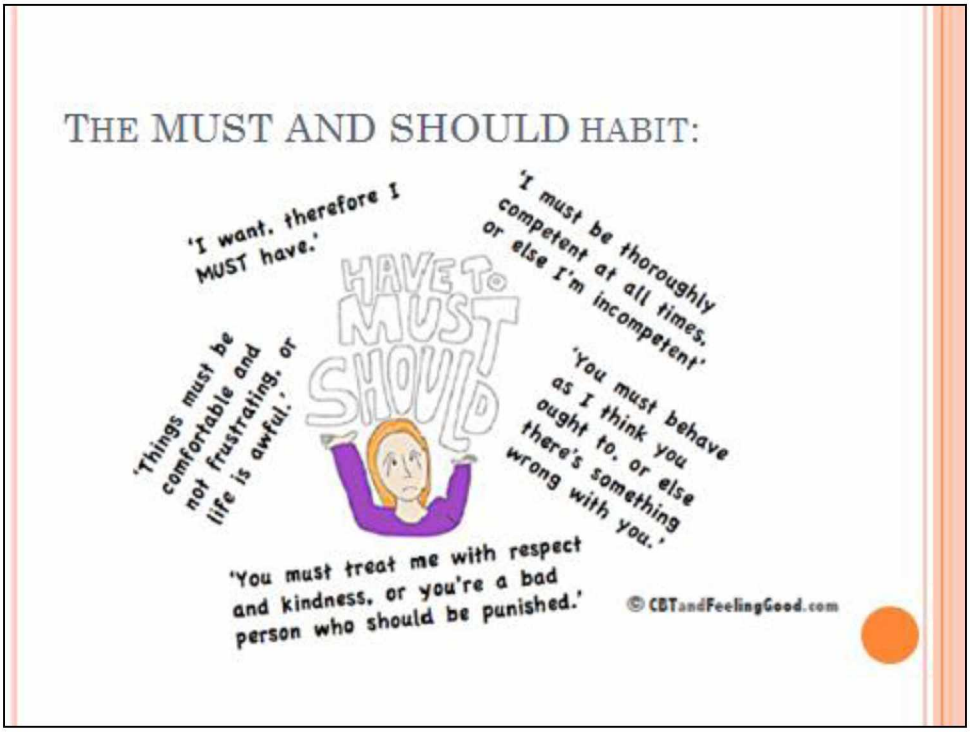
- See handout
- Feelings are not facts.
- Negative feelings can lead to self-sabotaging behaviors.
- Humans have a fight or flight reaction to stress and fear.
- Try to increase awareness of body, both thinking and feeling.
- Practice coping skills (e.g., deep breathing, reframing thoughts).
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)



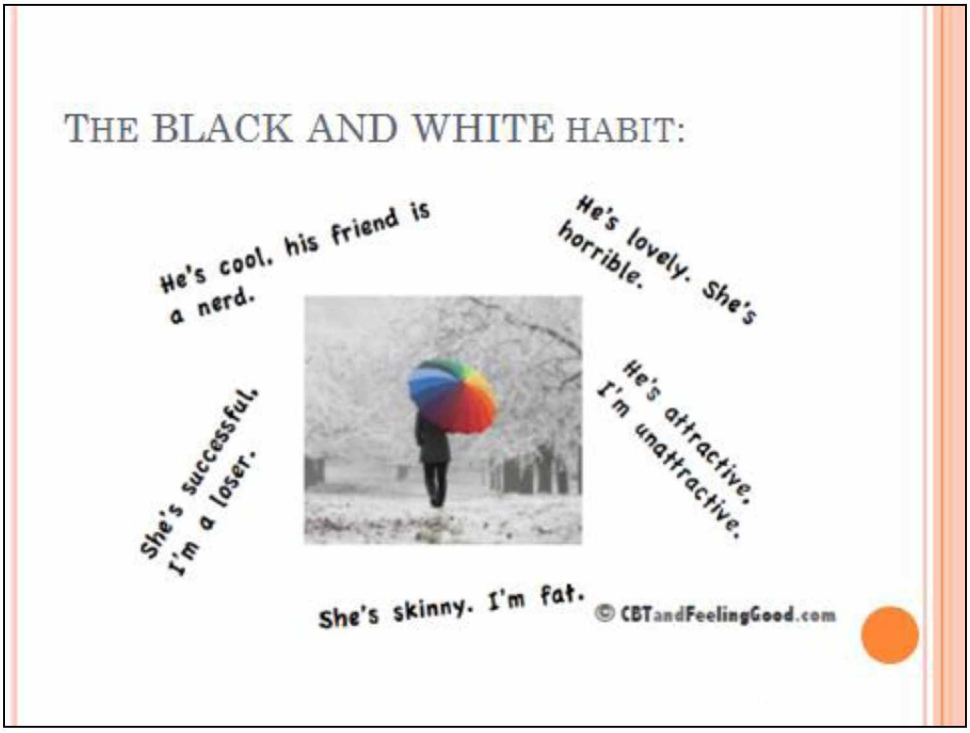
- See handout
- This habit is like making mountains out of mole holes.
- Believing in this negative self-talk can lead to a vicious circle of damaging self-perceptions and low self-esteem.
- Challenge your thoughts.
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)



- See handout
- This habit is like 'demand thinking' or inflexible thinking for the rules of living
- Things must be a certain way.
- Practice reframing and changing musts to preferences. Musts are illogical.
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)



- See handout
- All or nothing thinking, no in between.
- Acknowledging the variation in our thought processes.
- Practice thought stopping and reframing negative thoughts with healthier more realistic thoughts.
- Take a moment to fill in your example of the fortune telling habit on the CBT handout.

(CBT and Feeling Good, 2015)

CLOSING

- Thank you for attending today!
- Questions and answers

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Appendix B: Glossary

Behavior Intervention Plan is a positive behavior intervention plan (also called BIP) created by the IEP team to modify a child's behavior to enable the child to gain educational benefit.

Department of Education and Early Development is the state agency responsible for ensuring that school districts comply with state and federal regulations.

Functional Behavioral Assessment is when a child's IEP or 504 team gathers information on a child and their behavior to determine the reason for that behavior.

Individualized Education Program is an education plan tailored to meet the needs of a child with a disability that lists the special education and related services the child needs to receive an appropriate education.

IEP Team is the people who work together to develop the IEP, including the child (if appropriate), the parent, regular and special education teachers, a school district representative, and evaluators or therapists as appropriate.

Individuals with Disabilities Education Act is a federal law that provides federal funds to states who educate children with disabilities

Office for Civil Rights is the federal agency responsible for ensuring that school districts comply with federal laws regarding discrimination.

Response to Intervention is the progress a student makes in response to appropriate instruction that is scientifically and research based.

Section 504 is the section of the Rehabilitation Act 1973 that specifically prohibits discrimination by schools that receive federal funds.

Special Education is specially designed instruction that meets the unique needs of a child with a disability. It is *not* a specific program or classroom.

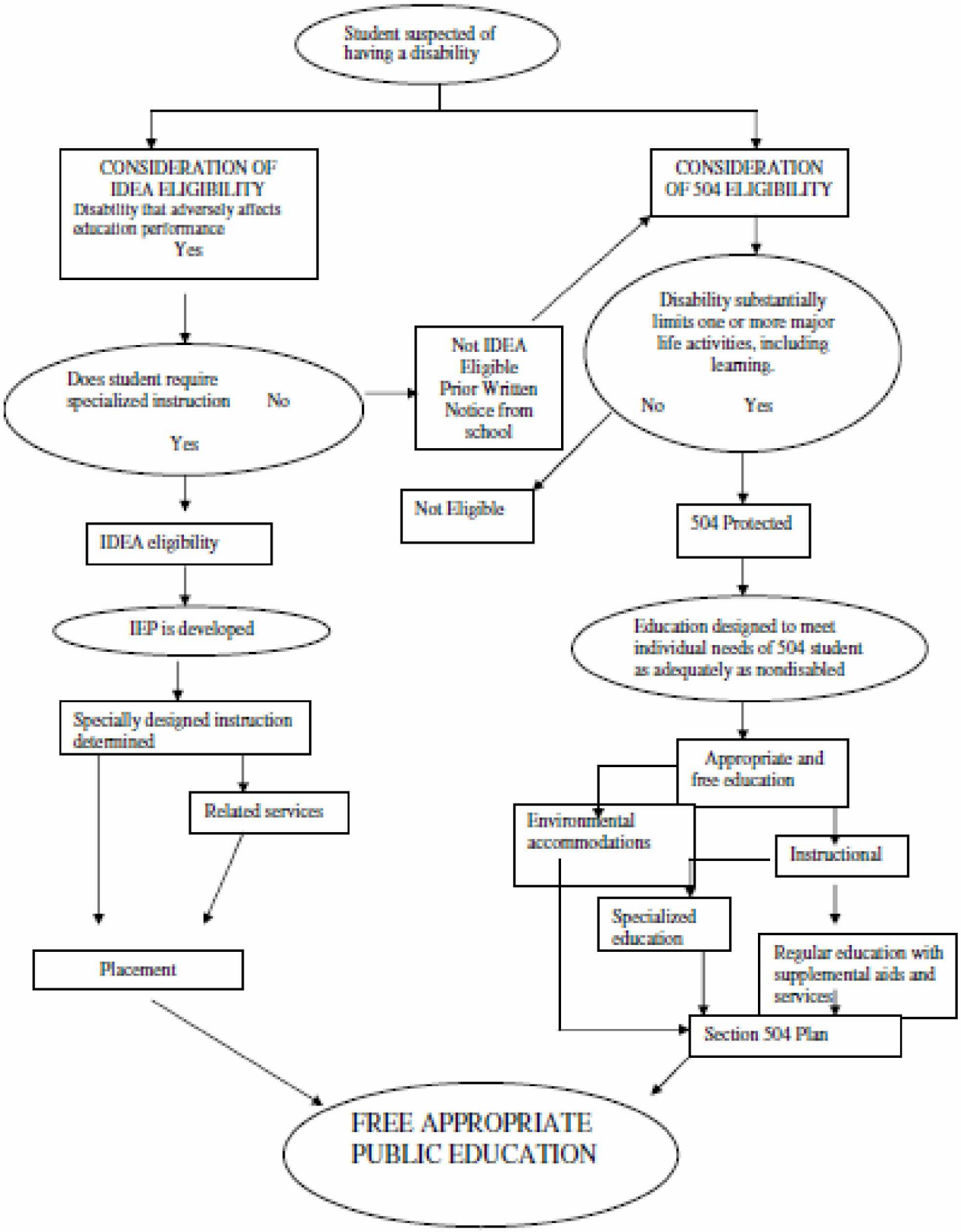
Supplementary aids and services means aids, services, and other supports provided in education related settings (including regular education classes) to enable children with disabilities to be educated with non-disabled children to the maximum extent appropriate.

Suspension is when a child is removed from school for behavior or as a result of a disciplinary action.

504 Plan is an educational plan designed to meet the needs of a child with a disability that is eligible under Section 504.

(Disability Law Center of Alaska. (2007). *Special Education & the Law.* Retrieved from http://www.dlcak.org/files/pdf/Publications/SpEdLaw.pdf)

Appendix C: IEP vs. 504



(Disability Law Center of Alaska. (2007). *Special Education & the Law*. Retrieved from http://www.dlcak.org/files/pdf/Publications/SpEdLaw.pdf)

Appendix D: Release of Information Form

Juneau School District

Consent/Request for Release or Exchange of Information

Student/Recipient's Name: _____

Birth Date: _____

Date of Authorization: _____
Date of Expiration:
Discharge from program or services _____ – OR –
Expires on this date: _____

I, _____, authorize the Juneau School District (10014 Crazy Horse Drive; Juneau, AK 99801)
(Parent/Legal Guardian)

I, _____, authorize the Juneau School District (10014 Crazy Horse Drive; Juneau, AK 99801)
(Recipient if 18 years of age or older or 14 years of age for Chemical Dependency)

**** Please INITIAL (do not mark with "X") all that could apply. Each section requires at least one selection. ****

_____(Int.) **Send Info to** - or - _____(Int.) **Request Info from** the following agency or person:

Name _____ Address: _____

This information is for the purpose of:

_____(Int.) Counseling or Mental Health Treatment
_____(Int.) Academic Performance
_____(Int.) Medical Treatment
_____(Int.) JYS School Base Program
_____(Int.) Safety of Self or Others

And may be released in the following format:

_____(Int.) Verbal and/or
_____(Int.) Written and/or
_____(Int.) Electronic

This release includes the following:

_____ (Int.) Academic & Attendance Records & Assessments
_____ (Int.) Special Education or 504 Records & Assessments
_____ (Int.) Medical Records & Assessments
_____ (Int.) Suicide Threat Report
_____ (Int.) Psychological Testing, when not included in Special Education Records
_____(Int.) Behavioral Records & Assessments
_____(Int.) Psychiatric Evaluation & Testing
_____(Int.) Treatment Plans & Reviews
_____(Int.) Homicidal Threat Report
_____(Int.) Chemical Dependency
_____(Int.) Other (please specify: _____)

No information will be released by the above-named person or organization to any persons or organizations unless I so authorize. I understand that my records are protected under federal regulation (42 CFR Part 2) governing confidentiality and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and cannot be disclosed without my written consent, except by court order, or unless otherwise provided for in regulation or notice of privacy practices. I understand I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it, or in the instance that this release is in conjunction with criminal justice related circumstances. Without my express revocation, this consent will automatically expire (1) on satisfaction of the legal need for disclosure, or (2) on the stated expiration date/event. I understand that I have a right to receive a copy of this request. I understand the information is to be used only for the purpose stated above and that it cannot be released to any other party or person except by court order. I understand that the potential for the information disclosed to be subject to disclosure by the recipient and no longer protected.

_____
Recipient's Signature (required for substance abuse treatment if 14 or older) Date

_____
Parent or Guardian's Signature Date

_____
Witness Date

If the recipient is a minor and being treated for alcohol/drug abuse, the signature of the minor is required by Federal Law. This information is being released to you from records whose confidentiality is protected by Federal Confidentiality Regulations (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), prohibiting you from making any further disclosure of this information except with the specific written consent of the person with whom it pertains. A general authorization for the release of medical or other information, if held by another party, is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal Confidentiality Regulations state that any person who violates any provision of this law shall be fined not more than $500 for the first offense and not more than $5000 for subsequent offense(s).

RECIPIENT'S NAME:	DOB:	DATE:

(Juneau School District. (2009). *Consent/Request for Exchange or Release of Information*.[Form].)

Page 1 of 1
1/19/09

ANCHORAGE SCHOOL DISTRICT
REQUEST FOR RELEASE OF HEALTH INFORMATION

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS AND SCHOOL DISTRICT

Completion of this document authorizes you to disclose and deliver individually identifiable health information including medical, psychological and/or other related records in your possession, including evaluations, assessments and/or _____ relating to the below-named patient. Completion also authorizes you to discuss this information with representatives of the organization named below entitled to receive said information.

The following types of records would not be released unless checked (*please check boxes*):

☐ drug/alcohol treatment ☐ mental health treatment ☐ HIV/STD status

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ Date of Birth: _____

Social Security Number: _____

I, the undersigned, do hereby authorize _____

(*name of agency and/or health care provider*)

to disclose and deliver the individually identifiable health information described for the named patient/student to:

Name: _____ Organization: _____

Address: _____

City/State/Zip Code: _____ Telephone Number: _____

PURPOSE:

This information is to be disclosed and used for the purpose of:

☐ Special Education Evaluation & Planning ☐ § 504 Evaluation & Planning

☐ Information for School Nursing ☐ Other _____ (*please provide explanation*).

YOUR RIGHTS:

I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective upon delivery to the records custodian of the above entities, but will not apply to information that has already been released pursuant to this authorization. My authorization for the use or disclosure of the information identified above is voluntary and I understand that a health care provider may not condition treatment on whether I sign this form. I also understand that I am entitled to a signed copy of this authorization.

REDISCLOSURE:

I understand that the requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District. If the disclosed information is not protected by FERPA, I understand that once it is disclosed, it may be redisclosed by the School District and the information may not be protected by federal privileges, privacy laws or regulations.

APPROVAL:

A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me. Unless sooner terminated in writing, this release shall remain effective for **1 year** from the date signed below. If the patient/student is under 18 years of age but is legally entitled to consent to treatment on his or her own behalf, the patient/student must sign this authorization.

_____ Date: _____

Signature of Patient/Student or
Patient/Student's Parent or Legal Guardian

Relationship: _____

(Anchorage School District. (2010). *Request for Release of Health Information*. [Form] Retrieved from http://www.asdk12.org/forms/uploads/Consent_ROI_HealthRecords.pdf)

Rev. 10/26/2010

Appendix E: Case Studies

Intervention Case Study 3

Introduction

Felix is a seventh grader at a school in Oregon. At the age of seven, Felix was hit by a car and suffered a traumatic brain injury, leaving him with physical and learning disabilities. He cannot use his right arm and leg to the full extent, and has difficulties with speaking and learning. Recently, Felix is exhibiting problem behaviors. He deliberately runs into other students in the hallways, he attempts to hit teachers and other students, and sometimes leaves classes and school without permission. His punishments include detention, referrals to the office, and suspension from school.

A team was established consisting of two of Felix's teachers, the vice principal of his school, his mother, and a member of the school-wide behavior support team. It is important for a team to not only include skilled professionals, but those people who best know and connect with Felix. In a school situation, it is also important to have team members involved in the school.

Measurement

The team used observation as well as interviews with his teacher and mother about what they tried to do to deal with problem behaviors in the past, Felix's schedule, his medical information, and his likes and dislikes. Felix's teachers also recorded when he engaged in problem behaviors throughout his school day.

Functional Behavioral Assessment

The team identified an escalating pattern of behavior for Felix. He would start with whining and when that was ignored he would move to pounding, then refusing to stop, then throwing things and hitting others, then leaving the room and destroying property. The team concluded Felix engages in such behaviors when faced with a difficult task, when teased by other students and chastised by teachers, or when cannot do something he wants to do.

Intervention

The goal was to help Felix behave more appropriately in those situations where he became frustrated and to teach him to communicate his frustration. A self-management system was used wherein Felix would make note of his own behavior and give himself points when he showed appropriate behavior. Felix was taught how to self-manage through the use of role play-so he was allowed to see in what situations he would give himself points, ask for a break, and ask for help.

For those times he still engaged in problem behavior, he would need to stay after school for the same length of time he spent engaging in the problem behavior. At the end of the day, Felix gives himself a plus if he has his materials and a plus if he does not tantrum, and zeros if he does not have his materials or tantrums. He verifies his records with the teacher, getting attention and feedback then at the end of everyday. Felix earns rewards for days with all pluses as well as more long-term rewards as the pluses accumulate.

Results

Felix is consistently more prepared and well behaved in class. He has also learned how to communicate what he is feeling better. Felix's time after school decreased as the intervention went on. For the first months of the intervention, he would have a major tantrum around once a week but in the later months he rarely did.

Todd, A., Horner, R., Vanater, S., & Schneider, C. (1997). Working together to make change: An example of positive behavioral support for a student with traumatic brain injury. *Education and Treatment of Children*, *20*, 425-440.

Intervention Case Study 4

Introduction

The curriculum of a student can have an impact on their behaviors and should be considered as part of a behavior management plan.

Gizelle is nine years old and in 4th grade. Her problem behaviors in school include aggressing toward her peers, taunting her teacher and peers, not working on task, leaving her seat without permission, and destroying property. Her English class has six other students in it with one teacher and one teacher's aide. During class, Gizelle is required to complete an assignment on punctuation, abbreviations, and capital letters followed by a coloring assignment.

Functional Behavioral Assessment

The team looked at Gizelle's history of academic achievement, mental health, and family. They also interviewed Gizelle's teacher, her parents and Gizelle herself. The interviews attempted to identify those activities Gizelle enjoys as well as what might trigger her problem behaviors. The team also observed Gizelle in class.

When asked to do a lesson from her textbook, Gizelle often sees how long the lesson is and refuses to do it. In her interview, Gizelle reported that she found the lessons too difficult. Gizelle has test scores showing she is four years below her grade level in reading and it was decided that she needed easier reading tasks. The team also concluded that Gizelle would talk back to the teacher less if she had more choices.

Intervention

Gizelle's assignment was modified with her reading level in mind. She was expected to read at a fourth grade level while her tests showed that she was at a first grade reading level. The team believed Gizelle's appropriate behavior would increase if the assignment was shortened, if she had more choices, and if visual cues were added to the instructions to help compensate for her reading level. Her assignments were divided and she was allowed to choose which section she did first. The assignments also included more examples of how to do the problems and important words in the instructions were underlined.

Measurement

Behavior was measured for 3-4 sessions while Gizelle completed the original assignment, 3-4 sessions with the modified assignment, then 3-4 sessions with a return to the original assignment, and finally 3-4 sessions with the modified assignment again. Observers looked at Gizelle's task engagement and problem behaviors during the sessions. Observers also measured how much attention the teacher gave.

Results

Gizelle had an average of 15% for problem behaviors while working on the original assignment and 0% for the modified assignment. She had an average of 16% task engagement while working on the original assignment and 99% while working on the modified assignment. She completed 90/137 of the problems from the original assignment and had 31% of those she

answered correct. She completed 126/126 items from the modified assignment and had 100% correct.

Dunlap, G., White, R., Vera, A., Wilson, D., & Panacek, L. (1996). The effects of multi-component, assessment-based curricular modifications on the classroom behavior of children with emotional and behavioral disorders. *Journal of Behavioral Education, 6,* 481-500.

Intervention Case Study 18

This intervention involves introducing school-wide positive behavior support at a middle school.

Introduction

Phoenix Middle School is a school in a rural area with approximately 530 students in grades 6-8. The middle school has staff and administrators committed to introducing schoolwide positive behavior support to their school.

Measurement

Researchers looked at the Office Discipline Referrals (ODR) for the school. Students received ODRs when they displayed problem behavior that could not be immediately dealt with by a teacher. Problem behaviors resulting in ODRs include tardiness, profanity, theft, vandalism, fighting, harassment, ditching, disruption of class, noncompliance, possession or use of drugs or a weapon, and repeated minor problem behaviors. The ODR included the problem behavior, student, date, and consequence. Staff looked at the ODRs to identify when and where problem behaviors were most likely.

Researchers collaborated with staff and administrators at the middle school. The team met weekly during the school year and conducted two hour long workshops with the entire staff of the middle school. The team decided that they needed a plan for the first day of school to teach students what was expected of them as well as a way to remind students of expectations throughout the school year.

Intervention

The team decided on five expectations for students: 1-be respectful 2-be responsible 3-be there and be ready 4-follow directions and 5-hands and feet to self. The team also identified how each expectation might look in different school contexts. For example, being respectful in the classroom might include listening to other students and being respectful in the cafeteria might include not cutting in line. Every student attended training at the start of the year to learn the expectations. They received the training in groups of 30 to 60 and spent 30 minutes in six main areas of the school (e.g. cafeteria, gym, classroom). At each area, students learned what appropriate and inappropriate behaviors were for that region, asked to display the appropriate behavior, and rewarded if they did display the appropriate behavior. Rewards consisted of tickets they could trade in for food. Trainers concentrated more on appropriate rather than inappropriate behavior.

Throughout the school year the team also put in place a plan that would remind students of the expectations. This involved asking students about the expectations while transitioning from one area of the school to another or reminding them of the expectations while they transitioned. Students received tickets they could exchange for treats when they displayed appropriate behavior and when given the ticket, staff identified what the student was doing right. If the student displayed inappropriate behavior they received a warning, detention, or an ODR. The team trained staff to be as consistent as possible in reminding, rewarding, and correcting students. During peak times of problem behavior (such as right before breaks), staff offered new rewards to students. The school also began a class especially for students with emotional and behavioral problems to provide those students with additional support.

Results

Before the intervention, an average of 15 students received an ODR a day. After the intervention, an average of 9 students received an ODR each day. A comparison of ODRs a month pre and post intervention showed that ODRs were less every month after the intervention except for one, in which they were equal.

Taylor-Greene, S., Brown, D., Nelson, L., Longton, J., Gassman, T., Cohen, J., Swartz, J., Horner, R.H., Sugai, G., & Hall, S. (1997). School-wide behavioral support: Starting the year off right. *Journal of Behavioral Education, 7*, 99-112.

(Kansas Institute for Positive Behavior Support. (2015, November 1). *Researched-based Case Study* Summaries. Retrieved from http://kipbs.org/sped_843/mod6/casestudylist.htm)

Appendix F: CBT Introduction Handout

CBTandFeelingGood.com – Handout – <u>Thoughts cause feelings & behaviours</u>

<u>Thoughts cause feelings & behaviours</u> This is the core theory of Cognitive Behavioural Therapy. All of the methods and techniques developed over the past decades – built from melding best practice (ie best results) from different styles and practitioners– flow out of that one simple premise.

So - Events *influence* feelings and resultant behaviours, they don't *cause* them. Our thoughts cause them. So it follows that if we can change *unhealthy* thinking to *healthy* thinking, we will feel and act in a way that's more constructive and doesn't cause us unhappiness or pain or anger or self-sabotage or whatever…

*Which brings the dilemma of how to **identify** and challenge the **thoughts** that cause your upsetting emotional disturbances and self-defeating behaviours… it's trickier than you may think!*

Example of unhealthy thinking and consequential behaviour:

Event: Your colleague snaps at you when you say good morning.

Thought: You think "Oh God, Tom really doesn't like me, and he certainly doesn't respect me. I'm so embarrassed. What did I do to make him treat me this way? It must have been that thing last week. Or maybe that other thing last month. Does everyone in the office feel this way about me? Of course they do! And I deserve it. I'm a xxxxxx (insert whatever negative you attach to yourself generally… you know who you are!)".

Feeling: You experience emotions that reflect this thinking – eg shame, embarrassment, stress, anxiety, hurt… take your pick. And your body reacts by jumping into 'fight or flight' mode (more on this later).

Behaviour: Your irrational unhealthy kneejerk thinking and resultant feelings cause self-defeating / self-limiting behaviour all that day and night, and most likely into the next day and perhaps the next… – often 'avoidance' – where you withdraw and stay away from people and interactions, feel tongue tied so become quiet, can't focus so procrastinate on work so you can endlessly 'worry' and 'awfulise' this 'horrible' thing that's happened that's 'unbearable', so you can re-run it as a movie in your head, perhaps changing the script ('I should have said xxx, and then he'd say xxx') etc. – –alternatively it can manifest as angry aggressive behaviour ("you *must* not treat me that way, you *should* behave appropriately and with respect, you deserve my wrath – actually everybodies going to get it because the world is '*awful*' and '*unfair*'…".)

CHANGE THE THINKING AND CHANGE YOUR FEELING AND BEHAVIOUR!

Alternative healthy example:

Event: Your colleague snaps at you when you say good morning.

Thought: You think 'Gosh, Tom is in a horrible mood! I hope it's not me personally he's annoyed at. Maybe he's feeling a bit low…'.

Feeling: You experience emotions that reflect this thinking – eg confusion, disappointment, concern, curiousity… but you don't assume you 'know' why he did what he did, or that it means you're a bad person or a loser, or that it has anything in particular to do with *your value* at all –you even wonder if you may have misinterpreted it.

Behaviour: Your rational balanced thinking and resultant feelings cause you to react in positive 'healthy' ways.

- You immediately tell Tom you feel he just snapped at you – maybe using humour - you ask if you've upset him in any way, or if he's just 'in the horrors' – you ask if he's OK.
- Alternatively you say nothing and 'let it go' and don't let it affect your self-esteem – you don't carry it around with you or use it as a stick to hit yourself with all day. You don't feel Toms behaviour or attitude defines who you are and your value. And you don't feel the need to badmouth Tom to everybody else and obsess and plot to punish him for his behaviour.

Do you see how the same event can cause different feelings and behaviour depending on your 'perception' of the event and of yourself? If your core belief is that you are an inadequate person, you'll be more prone to the first scenario – whereas if you have a healthy acceptance of yourself, and a belief that you're a worthy individual, the second scenario is more likely.

We can make it so that the second scenario is natural for us – just takes a little work! With CBT… we can identify and change...

Task: review the following basic CBT exercise to prove the premise…

First: **think of an occasion when you were very emotionally upset**, when you were not happy with the way you felt or acted… then ask yourself the following questions (later on we'll do this on paper as an exercise, for now, just think about it…):

- **What thoughts were you thinking?** (exact 'statement' thoughts not vague descriptions)
- **What emotions were you feeling** (eg stressed, anxious, jealous, angry etc. Can have several)
- **What was your body doing?** (were there any physiological reactions to your emotions?)
- **What did you do?** (what was your behaviour, how did you act? in a way that made the situation better or worse?)

Second: **think of an occasion when you were *delighted* with yourself** – when you were thinking positively and behaved in a way that made you proud to be you… and then apply the above list of questions to this situation!

See the difference? Can you make useful observations? Do you agree that your negative/positive thinking and perception and attitude caused your feelings and behaviour? This simple exercise can be done as often as you like, and will serve to help with rational evidence to dispute automatic negative thoughts in the *ABC* exercise.

THINK ABOUT THINKING WITH CBT!

Appendix G: CBT Habits

Common unhelpful thinking habits / irrational cognitions:

modern psychotherapy tells us that when stress becomes a disorder it causes a shift in thinking – and we filter and process situations and events though a distorted and gloomy lens. The 'picture' is off track, and it is not the situation that is causing our upset, it is our judgement of the situation (to paraphrase the philosopher Epictetus).

The following are the most common thinking patterns people with anxiety and depression develop. *Note*: all of us do some of these some of the time, but when we adopt many of them as our natural default position, we have a problem. **Can you see yourself here?** If you can, don't worry, that's a good thing! It means you have the ability to self critique, and that if you put the work in, you can dismantle those habits and build new ones using rational thinking skills with CBT.

The FORTUNE TELLING habit:

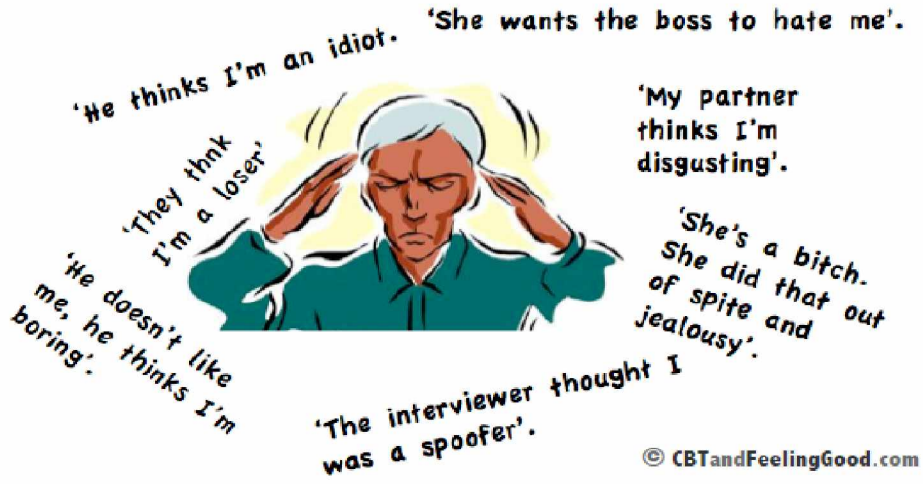
This is when we have a habit of predicting negative outcomes for situations and events:
'I'm not dating that person, it would never work out'. 'I'll go but I won't enjoy myself'. 'That won't work out, so here's no point in trying'. 'I wouldn't be able for that. Maybe in a few weeks or a few months'. 'I'll aways be alone.' 'Nothing ever works out for me'.

We think that we are anticipating and problem solving when we do this, saving ourselves from pointless effort or hurt or disappointment – but actually **WE DO NOT HAVE FORTUNE TELLING SKILLS**, so these *absolute* statements and beliefs, this self talk, cannot be trusted – believing these thoughts will cause self sabotaging behaviour (especially avoidant behaviour), and will stop us having a stimulating life where we take risks and see opportunities and excitement and live in the moment – rather than viewing everything as a negative and a hazard to be avoided.

Consider: if you were loved up and really happy in life would you have this kind of thinking habit? No, you would be viewing life through a different lens. So, it isn't 'life', it's your view of it. Is there any evidence for your thought and belief? Is there any evidence against it? What are the facts?
Build awareness of your thoughts, and examine and challenge them. **Review, reappraise and reframe.** Changing how you think changes how you feel which changes how you behave....

Give an example of how you might use this habit:

The MIND READING habit:



'He thinks I'm an idiot'. 'She wants the boss to hate me'. 'My husband thinks I'm disgusting'. 'She's a bitch, she did that out of spite and jealousy'. 'The interviewer thought I was spoofing'.

If you were confident and happy would you have this kind of habit where you constantly ascribe negative thoughts and traits to people?

WE DO NOT HAVE MIND READING SKILLS. Those are your thoughts, not theirs. Those are your assumptions – and they cannot be relied upon when we have an emotional health disorder and we're filtering life through the negative lens. Thought stop and reframe.

Give an example of how you might use this habit:

The EMOTIONAL REASONING habit:

'I feel bad, therefore it is bad'. 'I feel angry therefore there is a reason to be angry'.

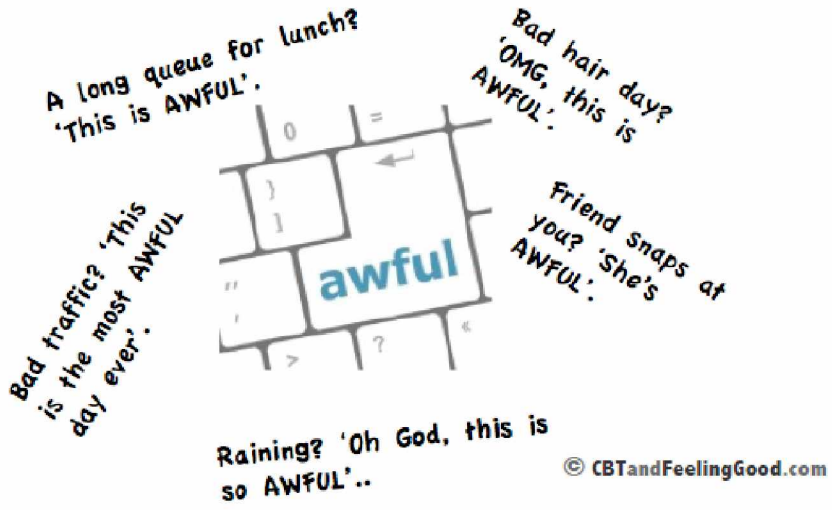
Actually, no, **FEELINGS ARE NOT FACTS**. This is hugely important in understanding and managing your emotional health when you're overly upset often, and have a pattern of self sabotaging behaviours.

Human beings have a primal **'fight or flight'** physiological response to stress and fear – releasing the stress hormones Adrenaline and Cortisol, which pump up our body to handle a physical threat or predator, even though today's threats are mostly psychological. This means our stress response to situations is not just emotional, it's literally physical too – symptoms of fight or flight include a racing heart, too much oxygen, the digestive system and immune system shutting down, veins dilating and causing blushing, the body sweating to cool itself down, and shaking and spacing out from an oxygen and adrenaline stimulus. Physical pumping up would be very handy to fight or run from a tiger, but it's very unhelpful as we try to go about the business of everyday life isn't it? If we have anxiety or depression, even low to moderate, we are hardwired for fear - and for many of us our systems can simmer in fight or flight mode inappropriately on and off throughout each day, with us not knowing what it is, just feeling shaky and not right. In extreme anxiety these symptoms escalate to actual panic attacks.

Accepting the above means that if we use **'emotional reasoning'**, if we depend on how we 'feel' to interpret situations, we will misinterpret what's going on. Adopt CBT coping skills. Build awareness of your *thinking* and ***feeling*** (both emotional and physical) and *behaving*. Examine it. Understand and accept your body and your primal condition. When you feel shaky and upset: pause, practice deep breathing to regulate your overload of oxygen, consider the facts of the situation, and reappraise and reframe with new self talk. Tell yourself'*There is no tiger*.' You have an anxiety disorder, your body is exercising it's design flaw when it interprets something as a danger or hazard. It is what it is. You can handle it. **CHANGE YOUR MIND, CHANGE YOUR MOOD**.

Give an example of how you might use this habit:

The AWFULISING habit:



A long queue for lunch? 'This is AWFUL'. Bad hair day? 'OMG, this is AWFUL'. Friend snaps at you? 'She's AWFUL'.

The way we talk to ourselves, **our self talk**, about situations and the world, the meaning and significance we attach to events, causes our physical and behavioural responses. We develop a habit of making mountains out of molehills when we use extreme language in response to pretty benign events – and when we believe and trust this 'self talk' – it turns on fight or flight, and starts a self fulfilling prophecy of a vicious circle that feeds itself. (Include other self talk like 'I can't cope' and 'I can't bear this' in this habit.)

This language just serves to maximise your discomfort. It is possible to challenge and change this habit, and to develop a new habit of using less incendiary and more appropriate rational words to describe events:

'I'm saying everyday nuisance things that happen are 'awful' again, this is just a bad habit that makes me overly upset, it's more true to say that this is an annoying inconvenience. but it is what it is and I'll accept and deal with it'.
'Ah now, I'm saying I can't cope again. That's silly and just makes things harder. It's more true to say I can cope, but I'm not coping well, and would prefer it if I didn't have to cope. I'll be okay, it'll be okay."

Give an example of how you might use this habit:

The MUST AND SHOULD habit:

(also known as musterbation {really}, and 'demand thinking', and inflexible 'rules for living)
'I want therefore I must have'.

'I must be thoroughly competent at all times, or else I am incompetent'
'You must behave as I think you ought to, and you must treat me with respect and thoughtfulness, or you are a bad rotten person'
'Things and conditions must be as I want them to be, and must never be too difficult or frustrating, or life is awful.'

Albert Ellis explains this as "The idea that it is horrible when things are not the way we like them to be... ... instead of the idea that it is too bad, that we had better try to change or control bad conditions so that they become more satisfactory, and, if that is not possible, we had better temporarily accept and gracefully lump their existence."

Reframe and **CHANGE MUSTS TO PREFERENCES**, because they are illogical (who made us a God of the world? Where is it written in the stones or stars that you can control the random world or the thoughts and behaviours of others?).

'I would prefer it if I were perfect and successful in all things, but I accept that I am exactly where I am at this moment, and that I'm a flawed human being that's just doing my best. I will make changes where I can.'
'I would prefer it if you behaved as I'd like you to behave, but I don't demand it and I accept that you choose your behaviour because of your thoughts and beliefs and feelings, and that you are governed by your own priorities.'

Give an example of how you might use this habit:

The BLACK AND WHITE habit:

(also known as 'all or nothing thinking' and the 'either / or fallacy')

This is when we think in absolutes. Things or people are:
Lovely or awful. . Clever or stupid. Attractive or unattractive. Nice or horrible. Skinny or fat. Happy or miserable. Successful or a loser. Cool or a nerd. Authentic or fake.

('Always' and 'Never' feature in black and white self talk too. *'Things always go wrong', 'I'll never be truly happy', 'she's always late', 'he's never going to grow up'....*)

Things are never really an either/or. There are a a whole spectrum of grays between extremes, but this habit does not account for that. Change the habit by monitoring your self talk, and by 'thought stopping' and reframing with new healthy realistic language instead:

'I'm doing my black and white habit here saying she's a horrible person and that I'll never speak to her again because she didn't behave as I expected her to - but it's more true to say that I'm sad and disappointed, that I think she's thoughtless'.
'It's silly to say my colleague is evil – it's more true to say that we don't get on. and that I don't understand him and disapprove of some of his behaviour.

Give an example of how you might use this habit:

Appendix H: CBT Case study

Case Study

This article presents a case study of "Alex," an 8-year-old boy with symptoms of behavioral disinhibition and inattention. The school psychologist treating Alex used CBT strategies to design a treatment that included parent-, teacher-, and child-focused interventions.

Alex was initially referred for an evaluation by his classroom teacher, "Ms. S," who was concerned about his disruptive and inattentive behaviors, including frequently leaving his seat, distracting his peers, and making careless mistakes in his written work. While Ms. S described Alex as a "bright" and "likable" child, she also reported that much of her time was devoted to managing his classroom antics. She noted that his classmates were frustrated with his behaviors, and she expressed the concern that he was increasingly socially isolated. For example, she recently observed several of his peers roll their eyes at him. On two recent occasions, Ms. S had Alex removed from her classroom due to his disruptiveness, and on both occasions her student assistant spent more than 30 minutes with him outside the class doing one-on-one assisted coursework. Ms. S requested assistance from the guidance center and the school psychologist in determining the cause of Alex's behavior problems and in generating intervention strategies. Following this referral, Alex's mother, "Ms. B," was contacted, and she consented to having Alex participate in an evaluation.

Table 1
Dysfunctional Thought Record for Ms. B

Date	Event	Automatic Thoughts	Emotion	Alternative Ways of Thinking/Dispute
3/1	Alex told me he has no homework today	He shouldn't lie to me about his homework!	Anger	It isn't helpful to think he shouldn't lie. Kids lie about homework sometimes, particularly if it is hard for them.
		I shouldn't have to monitor his homework assignments!	Frustration	Alex has ADHD, and it makes sense that he needs extra help following through and organizing himself to do homework. I'm glad that I'm available to help him.
		He'll never be independent!	Anxious	Alex is in second grade. It's normal for him to need help, even more so because he has ADHD. This doesn't mean he'll never be independent!

Appendix I: Community Supports in Alaska

Association for the Education of Young Children- AEYC

- Services from birth to age 8
- Early literacy and educational supplements
- Child care referrals
- Services are free

907-696-5884

Services provided statewide: main offices – Anchorage, Fairbanks, & Juneau

http://www.alaskaaeyc.org/

Big Brothers Big Sisters of Alaska

- Services from 6 to 18 years old
- School based programs
- Community based programs
- Mentoring
- Services are free

907-433-4600

Services provided statewide

http://www.bbbsak.org/

Boys & Girls Clubs Alaska

- Services available up to 18 years of age
- Education & career programs
- Character & leadership programs
- Health & life skills
- Services are free

907-248-5437

Services provided statewide

http://www.bgcalaska.org/

Copper River Native Association

- Services for Alaska Native beneficiaries in surrounding villages
- Supports for health, behavioral health, & tribal community services

907-822-5241

Copper Center, Alaska

http://crnative.org/

Division of Vocational Rehabilitation (DVR)

- Serves individuals 18 years and older with disabilities seeking and maintaining employment
- Services are free
- Job search, placement, training, goal setting, & tutoring services

907-269-3580

Services provided statewide

http://labor.alaska.gov/dvr/

Juneau Alliance for Mental Health Inc. (JAMHI)

- Serves individuals with mental illnesses
- Case management/rehabilitation
- Emergency services/crisis interventions
- Drop-in services

907-463-3303

Juneau, Alaska

www.jamhi.org

Juneau Youth Services

- Serves youth 10-18 years old and their families
- Intake and assessment center
- School Based Services (SBS)
- Residential Facilities

907-789-7610

Juneau, Alaska
www.jys.org

Providence Behavioral Medicine Group

- Child, adolescent, and family services
- Outpatient psychiatric care
- Provides treatment, diagnosis, or help with mental/behavioral health concerns
- Crisis intervention

907-761-5800
Anchorage, Kodiak, Matanuska-Susitna Valley, Seward, & Valdez
www.alaska.providence.org

SouthEast Alaska Regional Health Consortium (SEARHC)

- Serves predominately Alaska Native/American Indian people
- Behavioral/Mental health services
- Dental, eye, and physical therapy

907-463-6693 (Juneau) or 907-966-8311 (Sitka)
Services provided in Southeast Alaska
www.searhc.org

Stone Soup Group

- Services from birth to age 26
- Supports for medical, disabilities, mental health, and special education concerns
- Parent navigation
- Training sessions
- Services are free

907-561-3701
Services provided statewide
http://www.stonesoupgroup.org/

Yukon-Kuskokwin Health Corporation

- Serves predominately Alaska Native/American Indian people
- Behavioral/mental health
- Health promotion and disease prevention programs
- Primary care

907-543-6000

Bethel, Alaska and surrounding areas

www.ykhc.org